Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

SERVICE CATEGORY:
CASE MANAGEMENT ADHERENCE
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Prepared by:
Training Resources Network
Lauren Deigh, BSW, MPA
Lori DeLorenzo, RN, MSN
Jeffrey A. Menzer, RN, ACRN
Susan Thorner, MA

Baltimore City Health Department
Ryan White Title I Office
Quality Improvement Program

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Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2001 QIP initiative focused on adult/adolescent primary care and case management services, while FY 2002 focused on medically related care and care coordination. The following service categories were reviewed during FY 2002:

- Substance abuse treatment services
- Mental health services: adults
- Mental health services: children and adolescents
- Case management adherence
- Client advocacy
- Co-morbidity services

To assess the degree to which the Standards for Case Management Adherence (Standards of Care) as established by the Greater Baltimore HIV Health Services Planning Council (Planning Council) were adhered to across the EMA, baseline data was gathered and analyzed from all Title I vendors in the EMA funded to provide the services listed above. Information presented in this report focuses exclusively on Case Management Adherence services.

Section 1. Methodology

Process

The one to three-day QIP reviews were conducted at 100% of four agencies providing Case Management Adherence services. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

Consumer Survey: The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) general information about the consumer; b) services received; and c) level of involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys is summarized in a separate report.

Agency Survey: Agency surveys were completed by 100% of the vendors providing Case Management Adherence Services. The tool is a self-report of how well the agency complies with the EMA Case Management Adherence Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 5. (See Appendix B for a copy of the agency survey.)

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendors' adherence to the Standards of Care as established by the Planning Council. The tool was developed by a content expert with demonstrated expertise in the area of case management and adherence-related services and was reviewed by BCHD and the Planning Council. In addition to questions pertaining to the Standards, the tool contained items relating to client demographics and descriptive items relating to service provision. (See Appendix A for a copy of the client chart abstraction tool.)

The Case Management Adherence Standards, ratified in January 2001, state that the "goal of the project [Case Management Adherence] is to provide intensive services directed toward identifying and remediating barriers that interfere with the consumer adhering to the needed medical services or following the planned medical treatments."[1] Additionally, these Standards state that the "Standards for Case Management [Section 10 of the EMA Standards, ratified October 1998] shall be used as service guidance for the provider agency organizations and the staff delivering services."[2]

Adherence services are considered a sub-category of the Case Management service category. By providing specialized adherence-related activities as an adjunct to the eight phase case management service, individuals are to be assisted in adhering to scheduled appointments or treatment regimens. The EMA's Adherence Standards provide a broad framework for the design of adherence-related services, but do not detail key adherence-related activities. The Adherence Standards do focus on the following items:

- Defining client eligibility;
- Location of adherence services;
- Service model, which includes a nurse, social worker, or case manager who may be partnered with a trained peer counselor;
- Assessing barriers, medical status and co-morbidities as part of the intake process;
- Developing an adherence intervention plan in conjunction with and signed by the client;
- Quarterly evaluation of the implementation plan; and
- Implementing a quality assurance plan and periodic reporting.

The QIP instrument developed for the review was based on the Adherence Standards, the Case Management Standards and a literature review of "best practices" and common adherence program components. The Case Management client chart abstraction tool developed in FY2000 was modified to incorporate the Adherence Standards and the identified best practices. By including additional questions about the agencies' adherence programs, descriptive program information was able to be captured. For the purposes of this report, standards relating to adherence activities are referred to as "Adherence Standards" and standards relating to the case management activities are referred to as "Case Management Standards".

Review Period

The review period focused on services provided in FY 2001 (March 1, 2001 to February 28, 2002) for Title I clients. Based on the number of clients reported receiving the Title I funded services during FY 2001, vendors were instructed to randomly select a specific number of patient charts who received services during the review period. Recommendations for obtaining a random sample were provided. In addition, vendors were instructed to include approximately ten charts that represent service initiated in FY 2001 and three to five closed charts. From the vendor-selected charts, the QIP reviewers selected a specified, smaller number of charts to review for adherence to the Standards. For each chart reviewed one survey instrument was completed.

The individuals conducting the QIP reviews had expertise in the service category being reviewed. Reviewers were trained in the QIP process, received written instructions for completion of the client chart abstraction instrument, participated in an orientation conference call, and were provided additional guidance as needed during the QIP review process. All completed client chart instruments were reviewed

[1] Greater Baltimore HIV Health Services Planning Council (2001, January), "Standards of Care", Section 24, page 1. Accessed from http://www.baltimorepc.org.
[2] Ibid.

for completeness and consistency and responses were entered into a customized database for subsequent analysis.

Sample

A total of 218 clients were reported to have received Case Management Adherence services during FY 2001. A total of 61 charts were reviewed at the four agencies, representing 27.9% of all reported Title I clients. The number of records reviewed per site ranged from 7 to 24, with an average of 15.25 charts reviewed per site (Table 1). The proportion of agency client records reviewed ranged from 17.9% to 36.8% of all reported Title I clients (Table 2).

Table 1. Case Management Adherence agencies reviewed, dates of review and number of Case Management Adherence client records reviewed

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
Good Samaritan Hospital	September 30, 2002	7	11.4%
Chase Brexton Health Services	October 7 — 9, 2002	16	26.2%
Bon Secours Health Systems	October 16, 2002	24	39.3%
University of Maryland	December 4 — 6, 2002	14	22.9%
Total		**61**	**100%**[3]
Average		15.2	25%
Minimum		**7**	**11.4%**
Maximum		24	39.3%

Table 2. Number of Case Management Adherence clients and proportion of Case Management Adherence client record reviewed

Agency Name	Reported # of Title I clients receiving Case Management Adherence services	% of EMA total	% of agency's clients reviewed by QIP
Good Samaritan Hospital	19	8.7%	36.8%
Chase Brexton Health Services	46	21.1%	34.7%
Bon Secours Health Systems	75	34.4%	32.0%
University of Maryland	78	35.7%	17.9%
Total	**218**	**100%**	**27.9%**
Average	54.5	25%	30..%
Minimum	**19**	**8.7%**	**17.9%**
Maximum	78	35.7%	36.8%

[3] Note on all tables: Due to rounding, the total may not be equal to one hundred percent.

Section 2. Client Demographics

Gender and Age

Of the population reviewed, the majority of clients (61%) were male and 39% female (Table 3). The mean age of clients was 41.1 years, with men on average being older than women, 42.6 years vs. 38.8 years (Table 4).

Table 3. Gender

Gender	n=61
Female	24 (39%)
Male	37 (61%)

Table 4. Age distribution

Age	n=61
20 –29 years	4 (7%)
30 – 39 years	22 (36%)
40 – 49 years	28 (46%)
50 – 59 years	7 (12%)
Mean age (n=61) Min 22.6 years Max 58.6 years	41.1 years
Mean age Male (n=37) Min 27.9 years Max 58.6 years	42.6 years
Mean age Female (n=24) Min 22.6 years Max 53.4 years	38.8 years

Race/Ethnicity

Eighty-two percent (82%) of the clients were African-American, and 8% were White (Table 5). Four percent of the women were White, compared with 11% of the men. Race/ethnicity and gender was not documented or missing for 8% of all clients, with race/ethnicity not documented for 13% of all women (Table 6).

Table 5. Race/ethnicity distribution

Race/Ethnicity	n=61
African-American	50 (82%)
White	5 (8%)
Hispanic	1 (2%)
Not documented	4 (7%)
Missing/Not abstracted	1 (2%)

Table 6. Race/ethnicity distribution by gender

Race/Ethnicity	Male	Female	Total (% of row)
African-American	30 (81%)	20 (83%)	**50 (82%)**
White	4 (11%)	1 (4%)	**5 (8%)**
Hispanic	1 (3%)	—	**1 (2%)**
Not documented /Missing	2 (5%)	3 (13%)	**5 (8%)**
Total (% of column)	**37 (100%)**	**24 (100%)**	**61 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Transmission risk

MSM was the most frequently documented risk factor (21% of all clients), followed by heterosexual transmission (20%) (Table 7). Slightly less than one-quarter (23%) had an intravenous drug use-related (IDU) risk factor. Risk factor was not documented in 30% of all client records reviewed.

For men, MSM was the most frequently documented risk factor (35%) (Table 8). For women, heterosexual transmission was the most frequent risk factor documented (33%). IDU-risk was comparable between men and women, 16% and 17%, respectively, but women had a much higher proportion of IDU and heterosexual risk factor than men; 13% and 3%, respectively.

Table 7. Risk Factor distribution

Risk Factor	n=61
MSM	13 (21%)
Heterosexual	12 (20%)
IDU	10 (16%)
IDU and Heterosexual	4 (6%)
Undetermined/Unknown	2 (3%)
Hemophilia/coagulation	1 (2%)
Not documented	18 (30%)
Missing/Not abstracted	1 (2%)

Table 8. Risk Factor distribution by gender

Risk Factor	Male	Female	Total
MSM	13 (35%)	—	**13 (21%)**
Heterosexual	4 (11%)	8 (33%)	**12 (20%)**
IDU	6 (16%)	4 (17%)	**10 (16%)**
IDU and Heterosexual	1 (3%)	3 (13%)	**4 (6%)**
Undetermined/Unknown	—	2 (8%)	**2 (3%)**
Hemophilia/coagulation	1 (3%)	—	**1 (2%)**
Not documented /Missing	12 (20%)	7 (29%)	**19 (31%)**
Total (% of column)	**37 (100%)**	**24 (100%)**	**61 (100%)**

Note: In this table, Not documented and Missing/Not abstracted categories have been combined.

Disease status, biological indicators and treatment status

More than one-half (56%) of clients had an AIDS diagnosis (Table 9). The mean CD4 value was 269/mm^3, with women having a higher mean CD4 than men, 287/mm^3 vs. 256/mm^3. Thirteen percent (13%) had a CD4 value of <50/mm^3, indicating severe immunological compromise and 15% had CD4 values greater than 500/mm^3. Forty-four percent (44%) had a viral load of greater than 20,000 c/ml while 16% had an undetectable viral load. CD4 and viral loads were not documented in 12% and 10% of the charts, respectively. 64% of clients were documented as being on HAART during the reviewing period (Table 9).

Table 9. Disease status, CD4 and viral load values, and treatment status

Disease Status	n=61
CDC-Defined AIDS	34 (56%)
HIV-infection	25 (41%)
Deceased	—
Not documented	1 (2%)
Missing/Not abstracted	1 (2%)
CD4 Distribution	**n=54**
‹50/mm^3	7 (13%)
50 – 199/mm^3	15 (28%)
200 – 499/mm^3	24 (44%)
› 500/mm^3	8 (15%)
CD4 values were not documented for 7 (12%) of all reviewed client records.	
Mean CD4 (n=54)	269/mm^3
Mean CD4 Male (n=32)	256/mm^3
Mean CD4 Female (n=22)	287/mm^3
Viral Load Distribution	**n=55**
Undetectable	9 (16%)
1 – 999 c/mL	4 (7%)
1000 – 6,999 c/mL	11 (20%)
7,000 -19,999 c/mL	7 (13%)
20,000 – 54,999 c/mL	10 (18%)
› 55,000 c/mL	14 (26%)
Viral load values were not documented for 6 (10%) of all reviewed client records.	
Treatment Status	**n=58**
64% of clients were documented on HAART at any time during review period	
HAART treatment status was not documented for 3 (5%) of all reviewed client records.	

Changes in biological indicators

In an effort to examine clinical and treatment outcomes, laboratory values (CD4 and viral load) and treatment information (HAART) were abstracted at two points during the review period. Of the 61 charts reviewed, two CD4 values were in 35 charts (57%); one CD4 value was documented in 19 (31%) charts; and no CD4 values were documented in 7 charts (11%).

Clients for whom there were two CD4 values (n=35) had a mean of 247/mm^3 at the first entry and a mean of 264/mm^3 at the second entry, representing a mean increase of 6.8%. Clients who were documented **on HAART** at any time during the review period and had two documented CD4 values (n=25) had a mean first value of 254/mm^3 and a mean second value of 279/mm^3. For these clients, there

was a **mean increase of 9.6%.** Clients who were **not on HAART** during the review period and had two documented CD4 values (n=10) had a mean first value of 229/mm^3 and a mean second value of 227/mm^3. For these clients, there was a **mean decrease of 1.8% (**Table 10).

Table 10. Mean CD4 changes for clients with two CD4 values

CD4 changes	1st mean CD4 value	2nd mean CD4 value	Mean change
All clients with 2 CD4 values (n=35)	247/mm^3	264/mm^3	+6.8%
Clients on HAART (n=25)	254/mm^3	279/mm^3	+9.6%
Clients not on HAART (n=10)	229/mm^3	227/mm^3	-1.8%

Insurance status

Insurance coverage was documented at the beginning or first entry of the review period and at the end or last entry of the review period. At this first entry, a majority of clients had Medicaid insurance. Fifteen percent (14.7%) had no insurance at the first entry and of these 9 clients, six (66%) had obtained health insurance by the end of the review period. Insurance status was not documented for 11% of clients (Table 11).

Table 11. Insurance status

Insurance status	First Entry
Medicaid	33
No insurance	9
Medicare	6
MPAP	4
Private/Commercial	4
MADAP	2
Not documented	7

Note: Multiple responses documented.

Residence

The most frequent ZIP code of client residence was 21217, followed by 21223. In 6.6% of charts, ZIP code was not documented; however, Baltimore City was noted as the city of residence. ZIP code or residence was not documented for 1.6% of client records (Table 12).

Table 12. Residence

ZIP Code	#/% of total
21217	8 (13.1%)
21223	5 (8.2%)
Baltimore, ZIP Code not documented	4 (6.6%)
21201	4 (6.6%)
21202	4 (6.6%)
21206	4 (6.6%)
21218	4 (6.6%)
21207	3 (4.9%)
21212	3 (4.9%)
21216	3 (4.9%)
21229	3 (4.9%)
21230	3 (4.9%)
21231	3 (4.9%)
21213	2 (3.3%)
21122	1 (1.6%)

ZIP Code	#/% of total
21211	1 (1.6%)
21214	1 (1.6%)
21215	1 (1.6%)
21239	1 (1.6%)
21244	1 (1.6%)
Missing; not abstracted	1 (1.6%)
Residence not documented in chart	1 (1.6%)
Total	**61 (100%)**

Comparison with Baltimore City EMA prevalence data

In comparison with reported Baltimore City EMA HIV/AIDS prevalence[4], the sample of client records reviewed is comparable in terms of gender. African Americans represented a slightly lower proportion of charts reviewed compared to Baltimore City prevalence data; 82% vs. 89% (Table 13).

Table 13. Demographic comparison of client records reviewed with Baltimore City EMA prevalence

Population	Reviewed client records	Baltimore City HIV/AIDS prevalence
% African-American	82%	89.0%
% White	8.2%	9.9%
% Adult Male (>13 years)	60.7%	62.7%
% Adult Female (>13 years)	39.3%	37.3%
% Ages 30 – 39 years	36.1%	30%
% Ages 40 – 49 years	45.9%	42%
% Ages 50 – 59 years	11.5%	15.6%

HRSA reporting categories

Client demographics, by HRSA reporting categories are reported below (Table 14).

Table 14. Proportion of client records reviewed by HRSA reporting category

Population	Reviewed client records
0 – 12 months	0 %
1 – 12 years	0 %
13 – 24 years	0%
Women ≥ 25 years	38.3%
African-American/Female	32.8%
African-American/Male	49.2%

[4] Baltimore City Health Department, HIV Disease Surveillance Program, "Baltimore City HIV/AIDS Epidemiological Profile", Third Quarter 2002. Prevalence data on September 30, 2001 as reported through September 30, 2002.

Section 3. Client-level assessment of compliance with EMA standards of care

Note: Case Management Standards (CM Standards) are indicated with an Arabic number (e.g., CM Standard 2.3.a). Adherence Standards (CMA Standards) are indicated with a Roman number (e.g., CMA Standard IV.a). This is the format used in the published Standards[5].

A. Consumer/Client Identification (CM Standard of Care 2.1 and CMA Standard of Care III)

The CM Standard of Care 2.1 focuses on the identification and screening of eligible clients. Eligibility is based on verification of HIV status, eligibility for Title I services and other criteria established by the vendor. Based on the results of the agency survey, 75% report having written policies and procedures regarding eligibility for services (Section 5, CM Standard 2.1).

If the client is determined to be eligible for Case Management Adherence services, then the process is initiated and intake is completed. If the client is not eligible for services, the vendor is expected to make suitable referrals. Because these activities generally occur prior to the opening of a Case Management Adherence record, documentation of referrals would not be captured if the client was deemed ineligible for service.

Of the 61 charts reviewed (44%), 27 clients were enrolled in Case Management Adherence services during the review period. Almost two-thirds (63%) of the charts documented the reason for enrollment (CMA Standard III.a), with the most frequent reason being initiation of HAART. Missed medical appointments and difficulty adhering to treatment regimens were other reasons frequently cited. All of the documented reasons for enrolling clients in CMA Services were consistent with the Standards.

Approximately three-quarters (74%) of the records documented the referral source, nearly all of which were internal referrals (n=20). (CMA Standard III.b). Of those 20 clients, 45% were referred by Case Managers, 45% by medical personnel, and 10% by other personnel.

Prior to receiving CMA Services, almost half (48%) of the newly enrolled clients were documented receiving traditional case management services; of these, 39% (n=5) were documented maintaining the same Case Manager. Previous enrollment in Case Management was not documented in 46% of the reviewed charts. Table 15 outlines compliance with components of client identification.

Table 15. Assessment of compliance with Standard of Care III

EMA Standard	Percent of reviewed charts meeting Standards
Those individuals who have missed medical or other related appointments in the past 12 months are eligible and individuals who are not following the planned medical regimen may be offered this service. [Adherence Standard III.a]	(n=27) 63% contained documentation of reason for inclusion in adherence case management.

[5] Greater Baltimore HIV Health Services Planning Council (2001, January). "Standards of Care".

Documented reason for referral	#
Initiating HAART therapy	7
Number of missed medical appointments	6
Difficulty adherence to treatment regimen	6
Need for social support	2
Case management related	2
Physician request for adherence support	1
Increased patient stressors	1
Not documented	10

Note: Multiple responses documented.

Referrals may be made from within the health care provider facility or from outside the health care provider facility or self referral. [Adherence Standard III.b]	74% contained documentation of referral source.	(n=27)

B. Intake (Case Management Standard of Care 2.2)

Case Management Standard of Care 2.2 outlines the key activities related to the intake process, which should be initiated within five working days after assignment to a Case Manager (CM Standard 2.2.c). As part of the intake process, an initial assessment is completed (Standard 2.2.a), emergency needs are assessed and addressed (Standard 2.2.b), and if needed, the client is assisted in making an appointment with a primary medical care provider (CM Standard 2.2.c). Table 16 outlines compliance with the various components of the initial intake process.

Table 16. Assessment of compliance with CM Standard of Care 2.2

EMA Standard	Percent of reviewed charts meeting Standards	
The agency shall complete an initial assessment on eligible consumer/clients at the time of intake, collecting all information as outlined on the service provider's intake forms. Completion of these forms is required for Intensive and Intermediate Case Management. [CM Standard 2.2.a]	67%	(n=27)

Level of case management	#/(% of total)
Intensive	5 (18.5%)
Intermediate/Periodic	2 (7.4%)
Limited/One-time	0 (0%)
Not documented	20 (74.1%)
Total	**27 (100%)**

Eligible consumer/clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment. Emergency needs are defined as needs that will have serious immediate consequences for the consumer/client unless these needs are met. [CM Standard 2.2.b]	0% *23 records were excluded from analysis; 21 were determined not to have an emergency need, 1 was not documented and 1 was missing/not abstracted.*	(n=4)

The consumer/clients will be seen for their first Case Management appointment within five (5) working days after assignment to Case Manager. Individuals requiring an off-site visit must be seen within ten (10) working days after assignment to a Case Manager. Exceptions are made if consumer/clients initiate cancellations. [CM Standard 2.2.c]	19%	(n=27)
The agency shall assist the client in identifying and making an appointment with a medical provider as early as possible during the time of the initial intake or the Case Management intake appointment for those consumer/clients not already connected to a primary medical care provider. Consumer/clients are to schedule their own appointments if they are able. [CM Standard 2.2.d]	57% *20 records were excluded from analysis; these clients had a documented source of primary medical care at time of intake.*	(n=7)

Of the 27 clients initiating services, 67% of the charts contained documentation that the intake was completed on the agency's forms (CM Standard 2.2.a). Four of the clients had a documented emergency need at the time of intake, but none (0%) of these were addressed by the conclusion of the intake appointment (CM Standard 2.2.b). Nineteen percent (19%) of the clients were seen by the Case Manager within the time frame established by the Standards. It should be noted that dates of referral and first appointment were poorly documented. As a result, timeliness of service provision could not be determined for 63% of clients (n=17) (CM Standard 2.2.c). While most of the clients had an identified source of primary care, **only 57% of those without a source of primary care (n=7) had assistance in making a primary care appointment** (CM Standard 2.2.d).

C. Psychosocial Needs Assessment/Resource Identification (Case Management Standard of Care 2.3)

CM Standard of Care 2.3 outlines the activities related to the needs assessment and resource identification process, which should be completed within 30 days or by the third case management appointment. The needs assessment focuses on 23 items that relate to the client's medical and psychosocial history (CM Standard 2.3a). The Case Manager is expected to provide documentation noting the identified needs were discussed with the client (CM Standard 2.3a[a]). CMA Standard VI.1 specifies that a nurse, social worker or Case Manager working in the adherence program is responsible for completing an assessment of barriers to adherence [6] Because CM Adherence requires an intensive level of client contact, CM Standard 2.3.b was determined not to be applicable to CMA clients. Table 17 outlines compliance with psychosocial needs assessment and resource identification.

Table 17. Assessment of compliance with CM Standard of Care 2.3 and CMA Standard of Care VI.1

EMA Standard	Percent of reviewed charts meeting Standards
The Case Manager shall complete a comprehensive written psychosocial needs assessment for each consumer/client within thirty (30) days or by the conclusion of the third Case Management appointment, which ever comes first. This needs assessment shall include a medical/psychosocial history and shall be included in the consumer/client record. This is required for Intensive and Intermediate Case Management. [CM Standard 2.3.a]	78% (n=27) (n=21) 67% of these were completed within the time frame. *6 charts were excluded because they did not have a needs assessment completed.*

[6] The CMA Standards are misnumbered. Standard VI is numbered IV. In this report, this Standard is numbered as VI.

Item in client history (n=21)	Percent included
Living Situation	76%
Financial status/entitlements	76%
Substance abuse history	71%
Mental health history	71%
Family composition	71%
Health insurance	67%
Legal history/issues	67%
Social/community supports	62%
Transportation	57%
Employment history	57%
Current medications	53%
Medical history	48%
Primary medical care provider history	48%
Current medical needs	43%
Child care needs	43%
Awareness of safer sex practices	43%
Presenting Problem(s)	33%
Current health status/symptoms	29%
Recent CD4	29%
Recent viral load	24%
Nutrition	24%
Recreational/social activities	5%
Physical/sexual abuse history	0%
Mean percent completeness	**48%**

Only those records with a client history (21 of 27) were included in the table above.
[CM Standard 2.3.a]

The Case Manager shall ensure that each consumer/client chart contains written indications that the current needs have been discussed and/or identified at the time of the psychosocial needs assessment. Case managers should review the listed areas of consumer/client needs when performing the psychosocial needs assessment. [CM Standard 2.3.a[2]]	11%	(n=27)
The agency should ensure that a mini assessment specific to the consumer/client identified problems is completed for any individuals requesting Limited or One Time Interventions. [CM Standard 2.3.b]	*Not applicable to case management adherence clients. Clients with demonstrated adherence problems require intensive or intermediate case management.*	
Assessment of barriers to adherence is performed by the nurse, social worker or case manager working in the adherence program. [CMA Standard VI.1]	22%	(n=27)

Of the 27 clients who presented for services, 78% had an assessment completed (Table 16).Two-thirds of these (67%) were completed within the specified time frame. Issues relating to the client's living situation, financial status, substance abuse, mental health and family composition were frequently assessed; while **issues relating to health status, health history, medical needs, and laboratory values were less commonly assessed.** The average rate of completion of the 23-item case management needs assessment was 48% (CM Standard 2.3.a). Only 11% of the charts contained documentation that these needs were reviewed and discussed with the client (CM Standard 2.3.a[2]). **Only 22% of the reviewed charts** contained documentation that barriers to adherence were assessed (CMA Standard VI.1). Of these, all but one were conducted by the Case Manager. The most frequently identified barriers were mental health issues (particularly depression) and isolation/lack of social support.

D. Consumer/Client Plan of Care (CM Standard of Care 2.4 and CMA Standard of Care VI)

CM Standard 2.4 specifies that a plan of care should be developed with the active participation of the client based on the data collected and analyzed during the intake and needs assessment. The plan of care should contain goals, objectives, time frames, and resources and be completed within 30 working days. (CM Standards 2.4.a and 2.4.b). The client is expected to sign the plan of care (CM Standards 2.4.a & 2.4.c) and intervention plan (CMA VI.3) to indicate either agreement or disagreement. CMA Standard VI.2 requires that a specific adherence intervention plan be developed in conjunction with the client. Table 18 outlines compliance with the client plan of care.

Table 18. Assessment of compliance with CM Standard of Care 2.4 and CMA Standard of Care VI

EMA Standard	Percent of reviewed charts meeting Standards
The Case Manager, shall, with the active participation of the consumer/client, identify which needs are to be addressed through the development of goals and objectives. Time frames for meeting the goals and resolving the problems should also be established. These written objectives and goals are to be incorporated into the plan of care which is a permanent part of the consumer/client chart. [CM Standard 2.4.a]	(n=27) 44% contained a plan of care (n=12) 33% contained goals. 8% contained time-framed objectives. *15 charts were excluded. Only those with a plan of care were included.*
Development of the plan of care shall be started by the third Case Management appointment or within thirty (30) working days from the date of assignment to a Case Manager. No plan of care is necessary for limited or one time intervention. [CM Standard 2.4.a]	58% (n=12) *15 charts were excluded. Only those with a plan of care were included.*
All plans of care should be signed and dated by both the consumer/client and the Case Manager. [CM Standard 2.4.a]	(n=12) 67% were signed by provider. 67% were dated by provider. 58% were signed by client. 17% were dated by client. *15 charts were excluded. Only those with a plan of care were included.*
The agency shall, together with the consumer/client, identify the appropriate resources needed to attain the stated goals and objectives. This resource identification shall be written in the plan of care. [CM Standard 2.4.b]	42% (n=12) *15 charts were excluded. Only those with a plan of care were included.*
The agency shall provide written verification that the consumer/client is either in agreement or disagreement with the goals and objectives contained in the plan of care. [CM Standard 2.4.c]	(n=12) 58% were signed by client. 17% were dated by client. *15 charts were excluded. Only those with a plan of care were included.*

Adherence intervention plan must be developed with the consumer/client. [CMA Standard VI.2]	11%	(n=27)
Clients must sign the intervention plan which may include contact with or from the peer counselor. [CMA Standard VI.3]	100% *24 charts were excluded. Only those 3 records with an adherence plan of care were included.*	(n=3)

Less than one-half (44%) of the reviewed client records documented a written case management plan of care. Of these, 33% contained goals and 8% contained time-framed objectives and 58% were completed within the specified time frame. Two-thirds (66%) of the care plans were signed and dated by the provider, while only 58% were signed by the client (CM Standards 2.4.a and 2.4.c) Resources were identified in 42% of the care plans.

Only 11% contained an adherence intervention plan with interventions specified to address the client's adherence-related needs and barriers (CM Standard VI.2) and all three were signed by the client (CM Standard VI.3). Of the six clients with an adherence assessment conducted (above, Standard VI.1), only two had a subsequent adherence intervention plan developed. Most of the interventions identified in the adherence plans involved patient support activities, such as daily reminder calls, provision of pill boxes and peer counseling.

E. Implementation and Coordination of Consumer/Client Plan (CM Standard of Care 2.5)

CM Standard 2.5 outlines the responsibility of the Case Manager to provide support, advocacy, consultation and crisis intervention to the client and others involved in the implementation of the plan. The Case Manager is expected to document referrals and outcomes made and to document the actions initiated by the client and others (CM Standard 2.5.c). CM Standard 2.5.d also delineates expectations regarding frequency of communication with the client. Case Management Adherence clients would be expected to receive the highest level of contact, "Intensive" which specifies a minimum of one contact per month and a minimum of one face-to-face contact every six months. Table 19 outlines compliance with implementation and coordination of the client plan.

Table 19. Assessment of compliance with CM Standard of Care 2.5

EMA Standard	Percent of reviewed charts meeting Standards	
The Case Manager shall proactively attempt to contact the consumer/client after the development of the plan to implement those parts that were not excluded at the time of the plan development. The plan will establish priorities among the identified needs. [CM Standard 2.5.a]	44%	(n=61)
The Case Manager shall advise the client on making arrangements with service providers selected and on ways of gaining access to those services. [CM Standard 2.5.b]	44%	(n=61)

The Case Manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client and other identified people and the outcomes resulting from these actions shall also be incorporated in the consumer/client record. [CM Standard 2.5.c]	41% contained documentation of referrals. 28% contained documentation of outcomes. 33% contained documentation of corresponding actions.	(n=61)
The Case Manager shall be in communication with the consumer/client during the Intensive level of Case Management, a minimum of one (1) contact per month to provide support, advocacy, consultation and crisis intervention throughout implementation of the client plan. [CM Standard 2.5.d]	46%	(n=61)

All client records reviewed (n=61) were included in this and subsequent Standards (Tables 19 – 30). Fewer than half of the reviewed charts (44%) documented that the Case Manager proactively contacted the client to implement the care plan and provide advice regarding accessing identified services (CM Standards 2.5.a and 2.5.b). Documentation of referrals was contained in 41% of reviewed charts with outcomes noted in only 28% of the charts. One-third contained documentation of corresponding actions initiated by the client and other identified people (CM Standard 2.5.c). An appropriate level of communication with the client (a minimum of one contact per month) was documented in 46% of the reviewed charts (CM Standard 2.5.d).

F. Monitoring the Consumer/Client Plan (CM Standard 2.6)

CM Standard 2.6 focuses on monitoring the care plan and provision of services, determining whether the goals and objectives are being met, and if not, providing appropriate intervention and revising the plan as necessary. CM Standard 2.6.a builds upon CM 2.5.d by specifying actions that should be taken to contact clients who can not be located. If the client can not be located, the provider is expected to terminate the client and close the file.

The Case Manager is expected to monitor the services provided (CM Standard 2.6.b) and document, through progress notes, difficulties encountered in achieving the care plan's goals and objectives (CM Standard 2.6.c). Table 19 outlines compliance with monitoring the client plan.

Table 20. Assessment of compliance with CM Standard of Care 2.6

EMA Standard	Percent of reviewed charts meeting Standards	
The Case Manager shall monitor the goals and objectives contained in the consumer/client plan (as the needs of the consumer/client require) to decide what steps need to take, if any. Documentation of the monitoring process shall be recorded in the consumer/client record. This monitoring shall occur a minimum of the following: • **Intensive:** Each client receives a minimum of one (1) contact per month from the case manager (two (2) face to face contacts a year – one (1) face to face every six (6) months) [CM Standard 2.6.a]	46%	(n=61)

If a client cannot be located, after several attempts to reach by telephone and/or letter, for two (2) months, a referral is made to case finding (if available) to assist in locating the client. [CM Standard 2.6.a]	4% *33 records were excluded because the frequency of client contact did not warrant referral to outreach.*	(n=28)
If the client cannot be located by the case finder within ninety (90) days, the case manager record is moved to inactive status. [CM Standard 2.6.a]	0% *33 records were excluded because the frequency of client contact did not warrant referral to outreach; 1 additional record was excluded because the client appropriately referred for outreach.*	(n=27)
At the end of the year, if there is no contact, the case management record is closed. [CM Standard 2.6.a]	0% *33 records were excluded because the frequency of client contact did not warrant referral to outreach. 3 additional records excluded, because: 1 client was appropriately referred and 2 clients were located.*	(n=25)
The Case Manager shall monitor the services provided and the service delivery to verify that the services are being received and are sufficient in quality and quantity. [CM Standard 2.6.b]	38%	(n=61)
The Case Manager shall provide written documentation (in the progress notes) of any difficulties encountered in achieving the goals and objectives, and provide strategies in writing for resolving these difficulties. [CM Standard 2.6.c]	32%	(n=61)

Nearly half of the (46%) charts documented appropriate level of client contact (CM Standard 2.6.a). Clients who were not engaged in on-going services did not receive the specified follow-up from the Case Manager and agency (CM Standard 2.6.a): 28 client records that did not document an appropriate level of client contact should have led to a referral to case finding. **Only one of those 28 client records (4%) documented appropriate referral to case finding**. None (0%) of the charts were moved to inactive status after unsuccessful attempts to locate the client, and no charts were closed at the end of the year due to a lack of patient contact (Standard 2.6.a).

More than one-third of all reviewed charts (38%) documented that the Case Manager verified that services were being received in sufficient quality and quantity (Standard 2.6.b). However, slightly fewer (32%) documented progress and included strategies or interventions to resolve difficulty in achieving goals (CM Standard 2.6.c).

Documentation of assessment and monitoring of patient adherence

The QIP review included the assessment of compliance of Standards relating to provider assessment of the client's care plan as well as documenting the activities documented by the vendor relating to provision of adherence-related services and documenting client treatment-related information. These assessed adherence-related activities included:

- adherence to appointment keeping;
- utilization of multi-disciplinary team meetings;
- documentation of laboratory values: CD4 and viral load;
- documentation of antiretroviral regimen;
- assessment of adherence; and
- assessment of new barriers or co-morbidities.

For each enrolled client, the QIP review assessed these adherence-related activities during each quarter of the review period.[7] For the 61 patient records reviewed, there was a total of 197 patient quarters. During the 4th quarter, all but one of the patient records are included. One patient record was closed due to patient death during the 3rd quarter. The table below lists the number of patients enrolled during each quarter. Findings for this section are based on analysis of the total number of patient quarters.

	1st quarter	2nd quarter	3rd quarter	4th quarter	Total patient quarters
# enrolled clients/open records	40	45	52	60	197

G. Re-Evaluation of the Plan of Care (CMA Standard of Care VI)

CMA Standard [VI].4 indicates that re-evaluation of client plan should be "performed periodically, quarterly." This is a more frequent re-evaluation than outlined in CM Standard 2.7.a which specifies a minimum of every six months. For the purposes of the QIP review, re-evaluation of the plan of care was assessed quarterly as specified in the Case Management Adherence Standards. Only 4% of client plans were reviewed on a quarterly basis (Standard VI.4) (Table 21).

Table 21. Assessment of compliance with CMA Standard of Care VI.4

EMA Standard	Percent of reviewed charts meeting Standards	
Evaluation of the implementation plan should be performed periodically, quarterly. [CMA Standard VI.4]	4%	(n=197)

1. Appointment adherence

Increased adherence to appointments is one of the goals of the CM Adherence program. The client chart abstraction tool was designed to abstract the number of appointments scheduled, kept and missed were to be tracked based on the appointment type (e.g., medical care, case management adherence, counseling, substance abuse, and mental health). Support services provided to clients to enable appointment adherence (e.g., transportation, child care, reminder call) were also to be abstracted. ***Due to a lack of systemic methods for tracking patient appointment adherence documented in the client record at any of the four sites, data related to appointment adherence could not be collected during the record review process.***

[7] Quarters were based on the review period: Quarter 1: March 1, to May 31, 2001; Quarter 2: June 1 to August 31, 2001; Quarter 3, September 1 to December 31, 2001; and Quarter 4: January 1 to March 31, 2002.

2. Multidisciplinary team meetings

Documentation of multidisciplinary team meetings held to discuss patient care needs were limited (Table 22). Multidisciplinary team meetings were documented in less than 10% of the total patient quarters.

Table 22. Documentation of multidisciplinary team meetings

Multidisciplinary meeting documented	# patient quarters/(% of total)
Yes	11 (6%)
No	184 (93%)
Missing/not abstracted	2 (1%)
Total	**197 (100%)**

3. Laboratory values

Slightly more than one-half of enrolled patients had CD4 (52%) and viral load (55%) testing performed for each reviewed quarter (Table 23). It is interesting to note that 100% of the agencies self-report using laboratory testing to assess patient adherence to medication (Section 5, Table 36).

Table 23. Documentation of CD4 and viral load testing

Laboratory testing	# patient quarters/(% of total)
CD4 testing documented	103 (52%)
Viral load testing documented	109 (55%)

4. Antiretroviral treatment

Based on a **patient-level** analysis, 64% (n=39) of the patients were on HAART at some point during the review period. A total of 41% (n=14) were on HAART during the entire review period. Thirty-six percent (n=22) of patients were not on HAART at any point during the review period.

On a **patient-quarter level** analysis, patients were on HAART during 103 of the 197 patient quarters (53%). The specific treatment regimen was documented for 73 of these 103 patient quarters (71%). While the patient records indicated the client was on HAART, the specific treatment regimen was not documented for 30 (29%) of the patient quarters (Table 24).

Table 24. Documentation of treatment regimen for patients who are on HAART

Patients on HAART	# patient quarters/(% of total)
Treatment regimen documented	73 (71%)
Treatment regimen not documented	30 (29%)

Treatment regimens

Over one-half (56%) of the documented treatment regimens contained three medications, 37% contained two, and 7% contained one (Table 25). Use of combination agents were frequently documented as part of the treatment regimen.

Table 25. Number of medications in treatment regimens

# medications in treatment regimen	# patient quarters/(% of total)
1 medications	5 (7%)
2 medications	27 (37%)
3 medications	41 (56%)
4 medications	0 (0%)
Total	**73 (100%)**

Treatment regimens were also analyzed on a scale which graded the complexity of the antiretroviral regimen based on three factors: inclusion of a protease inhibitor in the regimen, frequency of dosing and number of daily pills and medication-related dietary restrictions. The Grades range from 1 to 4, with 1 being the least complicated regimen and 4 being the most complicated (Table 26).[8]

Almost two-thirds (62%) of the documented regimens were Grade 2 and none were Grade 4. Almost all of the regimens had a three-times daily or less frequent dosing and no medication-related dietary restrictions.

Table 26. Complexity of treatment regimens

Grade	Criteria	# (% of total)
Grade 1	No protease inhibitor bid dosing No dietary restrictions	17 (23%)
Grade 2	May/may not include protease inhibitor tid dosing <= 8 pills/day bid dosing <= 10 pills/day No dietary restrictions	45 (62%)
Grade 3	Includes protease inhibitor tid dosing <= 14 pills/day bid dosing <= 16 pills/day With or without dietary restrictions	11 (15%)
Grade 4	Includes protease inhibitor qid or tid dosing > 14 pills/day With dietary restrictions	0 (0%)

Treatment changes

A total of 20 treatment regimen changes were documented (Table 26). The most frequently documented reason for a change was due to the patient-initiated discontinuation of the prescribed treatment regimen, followed by adverse side effects (Table 27).

Table 27. Reasons for treatment regimen changes

Reason for treatment change	#
Patient discontinued regimen	7
Adverse side effects	5
Patient request for change	4
Reason not documented	3

[8] This grading scale was modified from a three-level scale described by Mathews, Christopher, et. al., "Prevalence, Predictors, and Outcomes of Early Adherence after Starting of Changing Antiretroviral Therapy" AIDS Patient Care and STDs 2002;16;157-172. Matthews' classification schema was modified to add a category to accommodate an option of a non-PI regimen with a lower pill burden (Grade 2).

Suboptimal virologic response	2
Toxicity	1
Documented resistance	1
Other	1

5. Assessment of adherence to antiretroviral therapy

For those patients who were on antiretroviral therapy (either with a documented regimen or a non-documented treatment regimen), **assessment of adherence to treatment was documented for 48 of the 103 patient quarters (47%) and not documented for 55 (53%) of patient quarters.** The most frequently used method was patient self report (39%), (Table 28). Other methods, although infrequently documented, included review of pharmacy records and pill box checks.

Table 28. Methods of treatment adherence assessment

Methods of assessment	# (% of all patient quarters)
No assessment documented	55 (53%)
Patient self report	40 (39%)
Review of pharmacy records	4 (4%)
Pill box check	3 (3%)
Pill counting by provider	2 (2%)
Home visit	1 (1%)
Directly Observed Therapy	1 (1%)

Note: Multiple responses documented.

6. Assessment of new barriers or co-morbidities

An **assessment of new barriers to adherence or co-morbidities was documented for 24 of the 197 patient quarters (12%).** Of these assessments, 13 instances of new barriers or co-morbidities were identified. These include: patient forgetfulness (2), confusion (2), access to treatment, active substance use, side effects, and increased patient stressors.

H. Closure (CM Standard of Care 2.8)

CM Standard 2.8 outlines the key components of terminating services and closing the case file. Closure of the case management chart may occur for a number of reasons, including the successful completion of the client's plan of care, client death, relocation, or request. Additionally, if the agency is not able to contact the client as outlined in the monitoring phase, then the chart should be closed (CM Standard 2.6.a).

The Standards specify that as part of the closure process, clients should be informed of their agency's re-entry requirements (CM Standard 2.8.a) and that file should be closed according to the agency's policies regarding termination and case closure and document these steps (CM Standard 2.8.b). Table 29 outlines compliance with CM Standard 2.8.

Table 29. Assessment of compliance with CM Standard of Care 2.8

EMA Standard	Percent of reviewed charts meeting Standards	
Prior to closure (with exception of death), the agency shall attempt to inform the consumer/client of the re-entry requirements into the system, and make explicit what case closing means to the consumer/client. [CM Standard 2.8.a]	100%	(n=1)

The agency shall close a consumer/client's file according to the procedures established by the agency. [CM Standard 2.8.b]	100%	(n=1)

Only one of the 61 reviewed records documented closure during the review period. The reason for closure was client relocation out of the service area. Client notification of re-entry requirements was documented for this one client (CM Standard 2.8.a) and the file was closed appropriately (CM Standard 2.8.b).

As discussed in the CM Standard 2.6.a above, **25 client records (41% of all records reviewed) should have been closed at the end of the year due to lack of adequate client contact. None of these records were closed.**

I. Reporting (CMA Standard of Care VII)

The EMA adherence Standards include provisions for reporting by the provider agencies (CMA Standard VII). The Standards refer to an Adherence Project reporting form, and specify that the form should include information on client medical status, barriers/co-morbidities and adherence interventions, in addition to elements on the agency's standard intake form. The Standard states that "The form is to be completed as appropriate and submitted periodically as the consumer progresses through his/her program."

The EMA has not developed or implemented the Adherence Reporting Form referenced in the Standards, or any report format specific to Case Management Adherence Services. Two of the agencies report having written policies regarding the timeframe for completion and submission of the Adherence Project reporting form (Section 5) (Table 30).

Table 30. Assessment of compliance with CMA Standard of Care VII

EMA Standard	Percent of reviewed charts meeting Standards	
The Adherence Project reporting form is required to be completed as appropriate and submitted periodically as the consumer progresses through his/her planned program. [Adherence Standard VII]	0%	(n=61)

Section 4. Client-level case management adherence outcomes

The QIP process also sought to determine what benefits the clients received from their Case Management Adherence services. Since one of the primary functions of Case Management Adherence services is to meet identified unmet client needs, this outcome of Case Management Adherence services was assessed in seven areas: 1) income assistance; 2) health insurance: 3) housing; 4) primary health care provider; 5) substance abuse treatment services; 6) emotional counseling; and 7) transportation/health-care related.

Adapting a case management outcomes evaluation methodology described by Mitchell H. Katz, MD and colleagues[9], the client records were reviewed to determine whether the:

1. Client's needs assessment identified a need in each of the six areas;
2. Client's care plan contained a goal to meet this identified need;
3. Client's record contained documentation of activities (e.g., progress notes or updated care plan) to meet this goal; and
4. Identified need was met through the provision of case management services.

Definitions of met and unmet need used for outcome analysis

Need	Definition of "Unmet "Need	Definition of "Met" Need
Income Assistance	✖ Being unemployed; and/or ✖ Not receiving any public assistance	✖ Being employed and/or ✖ Receiving some public assistance
Health Insurance	✖ Having no health insurance; and/or ✖ Having inadequate insurance to meet needs ✖ Experiencing difficulty obtaining referrals/assignment to HIV primary care and/or specialty providers from MCO	✖ Having a form of health insurance and/or ✖ Having insurance to meet unmet need ✖ Obtaining necessary referrals/assignment to HIV primary care and/or specialty providers from MCO
Housing	✖ Being unstably housed; ✖ Living in shelter, SRO, doubled-up; ✖ Living in situation other than one's own house, apt., supported living	✖ Being stably housed ✖ Living in one's own house, apt., supported living
Primary Health Care Provider	✖ Not being able to identify primary health care provider/agency for HIV and other health care needs	✖ Being able to identify a primary health care provider/agency for HIV and other health care needs; ✖ Being able to report current CD4 count, viral load, treatment regimen
Substance Abuse Treatment Services	✖ Self reported drug or alcohol use and/or dependence during period before intake; ✖ Use of illicit/prescription drugs known to cause dependence; ✖ Use of more drugs than intended; ✖ Present of emotional/psychiatric problem associated with drug use	✖ Having received professional substance abuse services or participating in a self-help group

[9] Katz, MH, et. Al., "Effect of Case Management on Unmet Needs and Utilization of Medical Care and Medications among HIV-Infected Persons" Annals of Internal Medicine 2001;135:557-565.

Need	Definition of "Unmet "Need	Definition of "Met" Need
Emotional Counseling	✖ Self-reported	✖ Having seen a mental health provider, attended a support group or seen a spiritual provider
Transportation/ Health-care related	✖ Self-reported ✖ History of missing health care related appointments due to lack of transportation	✖ Having transportation needs met; enabling compliance with health care related appointments

For purposes of this outcomes review records that contained a recent care plan as well as those which contained a care plan from the prior grant year were included in the sample size. A total of 25, 41% of the total client records reviewed, were included in this outcomes review.

Health insurance was the most commonly identified unmet need, 52% of all records, followed closely by income assistance and substance abuse treatment, both 32% of all records (Table 30). Requiring a primary health care provider was the least frequently identified unmet need, with none of the records with a care plan identifying this as an unmet need. Almost all of the clients with an unmet need for health insurance had this need met (92% of those with an unmet need). In contrast, only 57% of clients in need of housing had this need met. Transportation was a frequently met need (83%) and approximately two-thirds of clients with identified needs in the areas of income assistance, emotional counseling and substance abuse treatment services had these needs met. Table 31 provides a summary of the findings of this outcomes assessment.

Table 31. Client-level Case Management Adherence outcomes

Note : For each service area, the percent of charts with an identified unmet need is listed (shaded row). The three subsequent rows—goal established, activities documented, and need met—the percentages are based on the number of charts with an identified unmet need.

Service Area	Discussion
Income Assistance % with unmet need: 32% % with goal established: 75% % with activities documented: 88% % with unmet need met: 75%	Income assistance was the second most frequently identified unmet need. Most of these clients had a goal established in their action plan and Case Management Adherence activities documented relating to income assistance. 75% of clients had this need met during the review period.
Health Insurance % with unmet need: 52% % with goal established: 100% % with activities documented: 100% % with unmet need met: 92%	Almost all (92%) of clients had their need for health insurance met during the review period. All had a goal established in their action plan and Case Management Adherence activities documented. Lack of access to health insurance for payment for medications is a possible barrier to adherence. Case managers appear to have a high degree of success in meeting this need when identified.

Housing

% with unmet need	28%
% with goal established	100%
% with activities documented	86%
% with unmet need met	57%

Housing was the third most frequently identified unmet need. While all of these clients had a goal established in their action plan and Case Management Adherence activities documented relating to securing housing, only 57% had this need met during the review period. Obtaining housing is both difficult and a lengthy process, so this level of achievement is not surprising. Lack of stable and/or adequate housing is also a possible barrier to adherence.

Primary Health Care Provider

% with unmet need	0%
% with goal established	0%
% with activities documented	0%
% with unmet need met	0%

None of the clients with a care plan had a need for a primary health care provider. It should be noted, however, that some of the patients without a care plan (and were not included in this outcomes analysis) had an unmet need for a primary care provider that was not addressed (Table 15).

Substance Abuse Treatment Services

% with unmet need	32%
% with goal established	63%
% with activities documented	75%
% with unmet need met	63%

Almost one-third (32%) had an unmet need for substance abuse treatment services. Of those, only 63% had a corresponding goal established and only 63% had their need met during the review period.

Given the high rates of IDU-related transmission risk among the charts reviewed as well as the prevalence of substance abuse in the Baltimore EMA, a higher rate of unmet need would be expected.

Case managers appear to have a moderate degree of success in meeting this need when identified.

Emotional Counseling

% with unmet need	24%
% with goal established	100%
% with activities documented	83%
% with unmet need met	67%

Only 24% had an unmet need for emotional counseling, 100% of which had a corresponding goal established in their action plan. A total of 67% had this need met during the review period.

Case managers appear to be routinely assessing mental health as well as substance abuse needs during the client intake (CM Standard 2.3.a) and for those few clients with an adherence assessment, many of the barriers identified were related to mental health needs. Case managers appear to have a moderate degree of success in meeting this need when identified.

Transportation/Health-care related

% with unmet need	24%
% with goal established	100%
% with activities documented	100%
% with unmet need met	83%

Slightly fewer than one-quarter (24%) had an unmet need for transportation services related to their health care appointments. All of these clients had a goal established in their care plan, with 83% having the need met. Case managers appear to have a high degree of success in meeting this need when identified.

Section 5. Agency-level assessment of compliance with EMA standards of care

As part of the QIP process, case management adherence agencies were asked to complete a six-page survey (See Appendices for a copy of the instrument). The purpose of this survey was to document the self-reported compliance with the EMA's Case Management and Adherence Standards pertaining to agency policies ad procedures. All data presented is self-reported by the agencies and the QIP process did not verify the agencies' responses.

Table 32 lists the services directly provided by the Case Management Adherence agencies and those provided through referral agreements. The four agencies provide a large number of services to clients, including primary care, and support services such as transportation and housing assistance. Substance abuse and mental health services, which are often barriers to adherence, are directly provided by 75% and 50%, respectively, of the case management adherence agencies. Agencies that do not directly provide substance abuse or mental health services do not have written referral agreements for those services.

Table 32. Services provided directly by Case Management Adherence agencies or through referral agreements.

Service category (n=4)	% which provide service directly	% with referral agreements
Case Management Adherence	100%	0%
Case Management	100%	0%
Client Advocacy	100%	0%
Ambulatory Health Care	100%	0%
Transportation	75%	0%
Direct Emergency Assistance	75%	0%
Viral Load Testing	75%	0%
Substance Abuse Treatment	75%	0%
Counseling	75%	0%
Housing Assistance	75%	0%
Outreach	50%	0%
Mental Health Services	50%	0%
Food/Nutrition	50%	25%
Co-morbidity Services	50%	0%
Dental Care	25%	25%
Legal Services	25%	25%
Buddy/Companion	25%	25%
Other: OB/GYN	25%	—
Enriched Life Skills	0%	0%
Other: Opthamology	0%	25%
Other: Pharmacy	0%	25%

A. Location (CMA Standard of Care IV)

CMA Standard IV specifies that case management adherence programs must be based in primary care facilities, community-based agencies or co-located with substance abuse or mental health providers. All of the agencies providing case management adherence are primary medical care providers. One agency is a community-based agency and the other three are part of larger tertiary care systems (Table 33).

Table 33. Agency-level assessment of compliance with CMA Standard of Care IV

EMA Standard	Percent of agencies reporting compliance with Standard	
a) Primary Medical Care Facility b) Community-based agency c) Substance Abuse or Mental Health Services Providers [CMA Standard IV]	100%	(n=4)

B. Service Model (CMA Standard of Care V)

CMA Standard V specifies the service models of the adherence case management programs and specifies the qualifications of staff and their case load. Table 34 outlines compliance with these Standards.

Table 34. Agency-level assessment of compliance with CMA Standard of Care V

EMA Standard	Percent of agencies reporting compliance with Standard	
The service model could include either of the following: Model A) a nurse, social worker, case manager; or Model B) a nurse, social worker, case manager partnered with trained peer counselor. [CMA Standard V]	25% Model A 75% Model B	(n=4)
Degreed Client Care Facilitator with a minimum BSW and five (5) years HIV experience or an MSW with two (2) years HIV experience. [CMA Standard V.A]	100% of agencies using social workers have staff who meet minimum requirements *One agency uses an RN for this service model and was excluded from analysis.*	(n=3)
Case load size between 30 and 35 active cases. [Adherence Standard V.A]	75%	(n=4)
The Peer Counselor must be HIV-positive, have experience working with HIV-positive consumers and be able to appropriately model adherent behavior. The Peer Counselor must have completed high school and completed training through a DHMH sponsored training program(s). [CMA Standard V.B][10]	Not assessed during QIP process	

Three of the four programs (75%) represent Service Model B, which pairs a trained peer counselor with a nurse, social worker or Case Manager (CMA Standard V). Social work staff at three programs meet the minimum education and or experience requirements. The fourth program delivers adherence services through a Registered Nurse. The professional staff all meet the minimum requirements specified in the Standard (CMA Standard V.A). Three of the four agencies (75%) report that staff have case loads consistent with the Standards (CMA Standard V.A).

The agency instrument also explored the operations of the adherence programs. Agencies report utilizing different methods of measuring adherence to appointments (Table 35). The most frequently reported method of measuring adherence to appointments (75%) was by contacting medical provider staff.

[10] Qualifications of the Peer Counselors were not assessed in the agency survey.

Half of the agencies report using consultation forms and 50% complete daily "no-show" reports. Only one agency measures appointment keeping through client self-reports.

Table 35. Agency reported methods of measuring appointment adherence

Method of measuring appointment adherence	% of agencies
Adherence staff contacts medical provider staff	75%
Consultation form/feedback from medical provider	50%
Daily no-show reports	50%
Client self-report	25%
Computer system reports	25%
Monitor caseload	25%

Similarly, the agencies report using multiple methods to measure adherence to treatment (Table 36). All agencies reported measuring adherence to treatment through CD4 count and/or viral load and three-quarters measure adherence through client self-report, pharmacy records and medical provider assessment.

Table 36. Agency reported methods of measuring treatment adherence

Method of measuring treatment adherence	% of agencies
CD4 and/or viral load	100%
Client self-report	75%
Pharmacy records	75%
Medical provider assessment	75%
Pill counting	50%
Drug level assays	25%
MEMS caps	0%

Agencies report providing other support services to clients enrolled in the case management adherence program. Three-quarters (75%) report providing transportation assistance and one agency reports providing child care (Table 37).

Table 37. Agency reported support services provided to case management adherence clients

Support services provided	% of agencies
Transportation	75%
Child care	25%
Case management	25%
Medication assistance	25%

C. Licensing (CM Standard of Care 3.0)

CM Standard 3.0 focuses on the licensing requirements of the agency and staff. All respondents (100%) indicate that their agency and staff are appropriately licensed (Table 38).

Table 38. Agency-level assessment of compliance with CM Standard of Care 3.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency/organization will show evidence of being licensed by an appropriate body. [CM Standard 3.0.a]	100%	(n=4)

Where applicable, staff will have licenses that are current and appropriate for providing Case Management services. [CM Standard 3.0.c]	100%	(n=4)

D. Training and Supervision (CM Standard of Care 4.0)

Standards of Care 4.0 focuses on the training and supervision requirements of Case Managers. The respondent agencies indicate a high degree of compliance with training and supervision standards. All agencies (100%) report that they document HIV-related staff education and encourage continuing education and professional development (CM Standards 4.0.a – 4.0.c) and 75% report having a system to regularly update staff on resources (CM Standard 4.0.d). Agency methods of updating staff of available services include staff meetings, memoranda, flyers, post-conference briefings, and "Lunch and Learns" (Table 39).

Table 39. Agency-level assessment of compliance with CM Standard of Care 4.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency will maintain documentation that demonstrates that Case Management services are provided directly by, or under the supervision of, or in consultation with a licensed social worker and/or registered nurse case manager. [CM Standard 4.0.a]	100%	(n=4)
The agency will maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS. [CM Standard 4.0.b]	100%	(n=4)
The agency will have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis. [CM Standard 4.0.c]	100%	(n=4)
The agency will create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS. [CM Standard 4.0.d]	75%	(n=4)

E. Practice (CM Standard of Care 2.0 and CMA Standards of Care IV &VII)

CM Standard 2.0 outlines the case management practice guidelines. Agencies were asked whether they had written policies which operationalize the specified practice standards and service expectations. CMA Standard VI requires that agencies have written policies regarding assessment of medical status and barriers/co-morbidities, and inclusion of planned interventions as part of standard intake forms. CMA Standard VI.4 indicates that implementation plans should be reviewed quarterly. CMA Standard VII specifies minimum reporting requirements (Table 40).

Table 40. Agency-level assessment of compliance with CM Standards of Care 2.0 and CMA Standards of Care IV & VII

EMA Standard	Percent of agencies reporting compliance with Standard	
Agencies reporting having written policies regarding the following case management and adherence practice outlined in the Standards of Care:		
a. Eligibility for service [CM Standard 2.1]	75%	(n=4)
b. Timeframe for addressing emergency needs identified during Intake [CM Standard 2.2b]	50%	(n=4)
c. Timeframe for scheduling of first case management adherence appointment [CM Standard 2.2c]	50%	(n=4)
d. Timeframe for completion of written psychosocial needs assessment [CM Standard 2.3c]	50%	(n=4)
e. Assessment/identification of medical status barriers/co-morbidities and planned interventions on standard intake forms [CMA Standard VI]	75%	(n=4)
f. Development of client plan of care [CM Standard 2.4a]	75%	(n=4)
g. Timeframe for the development of client plan of care [CM Standard 2.4a]	50%	(n=4)
h. Review of plan of care with client and signing and dating of plan of care by both case manager and client [CM Standard 2.4a/2.4c]	75%	(n=4)
i. Documentation of referrals and outcomes [CM Standard 2.5c]	75%	(n=4)
j. Quarterly evaluation of adherence intervention plan [CMA Standard VI.4]	50%	(n=4)
k. Timeframe for re-evaluation of client plan of care [CM Standard 2.7a]	50%	(n=4)
l. Timeframe for referral of clients lost to follow-up for case finding assistance [CM Standard 2.6a]	50%	(n=4)
m. Time frame for moving client file to inactive status [CM Standard 2.6a]	25%	(n=4)
n. Timeframe for closure of case management file [CM Standard 2.6a]	50%	(n=4)
o. Timeframe for completion and submission of Adherence Project reporting form (CMA Standard VII)	50%	(n=4)

Compliance with the standards varies greatly (Table 40). No Standard is met by all of the agencies. Three-quarters of agencies (75%) report having policies and procedures for the initial phases of case management (i.e., eligibility, assessment, development of a client plan of care), and fewer agencies (50%) have policies and procedures in place related to monitoring, re-evaluation of plans and closure of inactive cases. Two agencies (50%) report having a policy regarding quarterly re-evaluation of the adherence plan (CMA Standard VI.4) and completion and submission of the Adherence Project reporting form (CMA Standard VII).

F. Consumer/Client Rights and Confidentiality (CM Standard of Care 5.0)

CM Standard 5.0 requires agencies to have policies and procedures established that delineate client rights and responsibilities, confidentiality and grievance procedures and how clients are informed of these rights and responsibilities. Table 41 outlines compliance with these Standards.

Table 41. Agency-level assessment of compliance with Standard of Care 5.0

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency. These policies and procedures include:		
A written agency policy on consumer/client confidentiality. [CM Standard 5.0.a]	100%	(n=4)
A statement signed by the consumer/client that states that existing policies and procedures regarding confidentiality, grievance, eligibility and services have been explained to the consumer/client. Copies of eligibility criteria and services available should be given to each consumer/client requesting services. [CM Standard 5.0.b]	25%	(n=4)
System for ensuring that case records are protected and secured. [CM Standard 5.0.c]	100%	(n=4)
A written, signed consent for the release of information of consumer/client information that pertains to establishing eligibility for agency services. [CM Standard 5.0.c[2]][11]	100%	(n=4)
A written grievance procedure. [CM Standard 5.0.e]	100%	(n=4)
A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client. [CM Standard 5.0.f]	100%	(n=4)
A statement that outlines process for both Voluntary and Involuntary Disengagement from Services. [CM Standard 5.0.g]	75%	(n=4)

While all vendors (100%) report having written policies regarding client confidentiality (CM Standard 5.0.a), consent for release of information (CM Standard 5.0.c[2]), grievance (CM Standard 5.0.e), statement of client rights and responsibilities (CM Standard 5.0.f), only one agency (25%) requires clients to sign a statement that these policies have been given to them (CM Standard 5.0.b) (Table 40). Three agencies (75%) report having a written policy regarding voluntary and involuntary disengagement from services (CM Standard 5.0.g).

G. Maintenance of Records (CM Standard of Care 2.8.c)

CM Standard 2.8.c address the requirement for retention of both adult and child client records (Table 42).

[11] The Case Management Standards are misnumbered. The Standard referenced should be numbered 5.0.d.

Table 42. Agency-level assessment of compliance with CM Standard of Care 2.8c

EMA Standard	Percent of agencies reporting compliance with Standard	
In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. For children (under 19) the record must be archived until the child reaches the age of 24 or six (6) years after death, if sooner. [CM Standard 2.8.c]	Adult records: 50% Child records 100%	(n=4) (n=1)

Half of the respondent agencies (50%) indicate compliance with requirements governing the maintenance of adult records (Table 412). The one child-serving agency reported compliance with this requirement.

H. Quality Assurance (CM Standard of Care 6.0 and CMA Standard of Care VII)

CM Standard 6.0 and CMA Standard VII require that a quality assurance plan be established to monitor the appropriateness and effectiveness of services and that consumers be involved in this evaluation process (CM Standard 6.0.g)

Table 43. Agency-level assessment of compliance with CM Standards of Care 6.0and CMA Standards of Care VII

EMA Standard	Percent of agencies reporting compliance with Standard	
The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of services. [CM Standard 6.0; Adherence Standard VII]]	75%	(n=4)
A process for consumer/clients to evaluate the agency, staff, and services. [CM Standard 6.0.g]	100%	(n=4)

Three-quarters (75%) of the agencies report having a quality assurance plan (Standards 6.0 and VII) (Table 43). All agencies (100%) report that they have a process for clients to evaluate the agency's staff and services; 100% report the use of client satisfaction surveys and 50% report having a consumer panel (Standard 6.0.g).

Section 6. Discussion

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of Case Management Adherence providers (n=4) receiving Title I funds during FY2001. A total of 61 records were reviewed, representing 27.9% of the reported Title I Case Management Adherence clients served in the Baltimore EMA.

The following items have a higher rate of compliance with the Standards of Care:

- Sixty-three percent (63%) of records of clients receiving an intake had their reason for inclusion in adherence case management documented; almost all of these were related to appointment or treatment adherence.

- Slightly more than three-quarters (78%) of clients presenting for an intake had a comprehensive psychosocial assessment completed, with 67% of these being completed within the specified time frame.

- Agencies providing Case Management Adherence services also provide a wide range of services to clients, both directly and by established referral agreement. All (100%) directly provide case management, client advocacy, and ambulatory care services.

- Standards relating to staff training and supervision are being met to a high, but not universal, degree.

- All agencies (100%) report having policies relating to client confidentiality, grievance and security of records and information.

- All agencies (100%) report having a process for involving consumers/clients in evaluation of the agency, staff and services.

- An assessment of client-level Case Management Adherence outcomes shows that the most common unmet needs are for health insurance, income assistance and substance abuse treatment services. The most frequently met needs include health insurance, transportation assistance, and income assistance. Housing was the most difficult need to meet.

- Three-quarters (75%) of the agencies report providing peer-support in addition to case management services as part of their adherence program.

- Forty-two percent (42%) of clients who were on a documented antiretroviral regimen had two medications in their regimen and 56% had three medications. Almost all of the treatment regimens had a lower daily pill burden without dietary restrictions. All of these factors may contribute to adherence to treatment.

- Patient self-report was the most frequent form of assessment of adherence to antiretroviral therapy documented.

A review of the data from the QIP process identifies several areas where there is a lower rate of compliance with the Standards of Care. These most notable areas are discussed below and include:

1. Assessment of client adherence and barriers to adherence for medical appointments, treatment regimens and co-morbidities;
2. Development of adherence-specific care plans to minimize or resolve the identified barriers;
3. Intensiveness of services and frequency of client contact;
4. Coordination of agency personnel and efforts relating to adherence, especially between case management and case management adherence activities;
5. Closure of records; and
6. Agency policies which establish practice expectations.

As a service category, Case Management Adherence was developed to more effectively meet the needs of clients who had difficulty adhering to treatment regimens or appointment schedules. Because the issues facing these clients are often complex, intensive case management is required and additional strategies need to be employed to enhance the client's ability to adhere to a prescribed program. When working with populations such as these, assessment of barriers to adherence is an important first step. In this sample, only 22% of clients who received an intake had a specific assessment of barriers to adherence. Few clients had an adherence plan developed to resolve or minimize the identified barriers. In four cases, the client charts documented an emergency need at the time of intake, yet none of these were addressed by the conclusion of the intake appointment.

Laboratory values can be used as one strategy to assess patient adherence to medications as well as to measure adherence with appointments and engagement with the primary medical care provider. While 100% of the agencies report using such a strategy, slightly more than one-half of enrolled patients had CD4 (52%) and viral load (55%) testing performed for each reviewed quarter.

When adherence plans had been developed, the client records did not demonstrate client involvement in the planning process. Across the agencies, standardized processes to routinely monitor and assess client adherence were not in place and were not being performed with the frequency expected. Assessment to adherence to treatment was documented for only 47% of patient quarters for those clients on antiretroviral therapy and no evidence of documentation of routine and systematic monitoring of patient adherence to appointments was found in the client record. While the agencies report having methods in place to assess adherence, the review of clients records found little supporting documentation.

The records reviewed did not document an appropriate intensity of services and of client contact. Of the records reviewed, only 46% indicated that at least monthly contact was made with the client. Of the charts reviewed, 41% documented referrals that had been initiated. Outcomes were documented for 28% of the charts.

Overall, collaboration and communication among members of the health care provider team are limited in respect to adherence-related activities. While most of the clients were referred from internal sources, concrete examples of collaboration among personnel are limited, including collaboration between Case Managers and Peer Counselors. Inconsistencies were noted to occur between medical provider documentation and Peer Counselor and/or Case Manager notes. For example, one client had his medication discontinued by the Physician, yet the Peer Counselor continued to make twice daily telephone calls to remind the patient to take the medication. In addition, Case Managers are not routinely assessing client factors which may be predictive of poor adherence (substance abuse and mental health issues) or predictive of good adherence (social, community and family supports). Only 63% of those clients with an identified unmet need for substance abuse treatment services had a care plan goal established to obtain this service.

During the review period, 28 client records documented levels of contact that should have led to a referral for case finding. Only one of the 28 records documented such referrals. Of all records reviewed, 41% should have been closed due to lack of adequate client contact. None of these records were closed.

While most agencies report having policies relating to client confidentiality, grievance and rights and responsibilities, fewer agencies report having written policies relating to service provision, such as frequency of client contact or re-evaluation of care plans.

As indicated above, 41% of all records reviewed should have been closed based on their level of case management contact. Not surprising, few of the agencies have policies relating to closure of files for clients who are lost to care. Given the population targeted for Case Management Adherence services, follow-up for clients lost to care should be a critical component of these programs.

Section 7. Recommendations

The primary recommendations for Case Management Adherence services focus on three areas: 1) priority areas for quality improvement projects; 2) review and revision of the Standards of Care; and 3) development of quality indicators for Case Management Adherence services.

Priority Areas for Quality Improvement Projects

As previously identified, the most notable issues related to the provision of Case Management Adherence services focus on six main areas: 1) assessment of client adherence and barriers to adherence for medical appointments, treatment regimens and co-morbidities; 2) development of an adherence-specific care plans to minimize or resolve the identified barriers; 3) intensiveness of services and frequency of client contact; 4) coordination of agency personnel and efforts relating to adherence, especially between case management and case management adherence activities; 5) closure of records; and 6) agency policies which establish practice expectations. As the EMA and individual vendors identify quality improvement projects to undertake, these six areas can be incorporated into those projects.

Review and Revision of the Standards of Care

As an initial step in the quality improvement process, it would be beneficial to review the Standards of Care of the three service categories that are closely linked: Case Management Adherence, Case Management and Client Advocacy. For each service category, the purpose and goal should be carefully assessed to minimize duplication and offer discrete services. As part of this process it would be helpful to determine the need for each service category and revise the Standards of Care appropriately.

Since the development of Standards of Care for Case Management Adherence, there has been considerable research and publication in the area of supporting patient adherence to HIV-related care and therapies. For example, the current version of the *Guidelines for the Use of Antiretroviral Agents in HIV Infected Adults and Adolescents*[12] contains a section on adherence, with specific patient and provider-focused strategies. The Special Projects of National Significance Program (SPNS) of the HIV/AIDS Bureau of HRSA has an ongoing initiative focusing on patient adherence[13]. The New York State AIDS Institute has published a publication titled *Promoting Adherence to HIV Antiretroviral Therapy: Best Practices from New York State*[14]. Additionally, many AIDS Education and Training Centers as well as industry groups have developed and disseminated adherence program models, many of which have been evaluated for effectiveness. Experimental studies have also been conducted with findings published in peer review journals and presented at conferences. As part of this review of Standards of Care, these identified best practices, model programs and research findings can be utilized in the development of revised Standards relating to assisting patients with appointment and medication adherences.

Within the currently published Standards, specific areas that should be addressed or enhanced include the following: 1) client eligibility; 2) intensity and level of service; 3) content of adherence assessment; 4) content of the adherence plan, including specification of interventions to support adherence; 5) implementing, monitoring and reviewing the adherence plan; 6) expectations of staff coordination, collaboration and communication; and 7) expectations of tracking of medical and case management appointments.

[12] http://www.aidsinfo.nih.gov/guidelines

[13] http://hab/hrsa.gov/special/adherence_index.htm

[14] http://www.hivguidelines.org/public_html/center/best-practices/best-practices.shtml

The Standards should also specify the client-level data providers should be expected to document not only as part of the client intake/initial assessment but also regularly update. These include:

- HIV-transmission risk
- CD4 value
- Viral load
- Current medications, including antiretroviral therapy
- Current primary medical care provider
- Case manager/case management agency
- Insurance status
- Mental health and social assessment (including substance use, housing)

Additionally, it may be beneficial to expand the routine reporting requirements to include type of treatment modalities or interventions provided and more client-specific utilization data that can be used to monitor trends.

Quality Indicators

As the Standards are revised, the incorporation of quality indicators is integral to the quality improvement process. By identifying the core indicators to track and trend, the expectation regarding service delivery are further clarified. Based on the review of the Standards and the data collected as past of the QIP review process, the recommended core quality indicators to track as part of Case Management Adherence services are identified in Table 44. Target performance goals have also been identified in this table, but the actual goal should be finalized in conjunction with BCHD and the Planning Council.

Table 44. Recommended Quality Indicators for Case Management Adherence Services

Quality Indicator [Reference]	EMA Mean Performance	Performance Goal
% of client records which document completion of an assessment of barriers to adherence, performed by a nurse, social worker or case manager. [Standard IV.1]	22%	90%
% of client records which document completion of an adherence intervention plan. [Standard IV.3]	11%	90%
% of client records which document reassessment of adherence intervention plan and barriers [by adherence support team and client] at least every three months. [Standard IV.4]	4%	80%
% of client records which document minimum levels of client contact for intensive case management clients. [Case Management Standard 2.6.a]	46%	90%
% of client records which document a referral to case finding for clients who cannot be located after two months of attempts to contact by telephone and/or letter. [Case Management Standard 2.6.a]	4%	80%
% of client records which document patient's current medications, laboratory values, and compliance with medical appointments and is accessible to all adherence support team members.	NA	90%

Appendices

- Appendix A. Client Chart Abstraction Instrument: Case Management Adherence
- Appendix B. Agency Survey: Case Management Adherence
- Appendix C: Case Management Adherence Standards of Care; revised September 2000; ratified January 2001. Greater Baltimore HIV Health Services Planning Council. http://www.baltimorepc.org.
- Appendix D. Case Management Standards of Care; ratified October 1998. Greater Baltimore HIV Health Services Planning Council. http://www.baltimorepc.org.

BCHD Quality Improvement Project
Case Management Adherence
Client Chart Abstraction Instrument

Section 1. Reviewer Information

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry in client chart)	
1.8	Chart end date (Date of last entry in client chart)	
1.9	Dates of services reviewed in chart	☐ 3/1/01 to 2/28/02 (Default) ___ / ___ / _____ to ___ / ___ / _____
1.10	Was chart **opened/initiated** for case management adherence during review period?	☐ Yes ☐ No; case management adherence services initiated prior to review period ☐ Not documented in chart
1.11	Was **chart closed/client terminated** from case management adherence services during review period?	☐ Yes ☐ No; client continued to receive case management adherence services throughout review period ☐ Not documented in chart

Section 2. Client Demographics

Instructions: Provide the requested information based on information contained in the client's chart.

2.1 Date of birth	___ / ___ / _____ ☐ Age on 2/28/02 if no dob in chart ____ ☐ Not documented in chart
2.2 Gender	☐ Male ☐ Female ☐ Transgender ☐ Not documented in chart
2.3 Race/Ethnicity	☐ White ☐ Black/African-American ☐ Hispanic/Latino/a ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ African ☐ Caribbean ☐ Other: Specify: ☐ Not documented in chart
2.4 HIV risk factor *[Check all that apply]*	☐ Men who have sex with men (MSM) ☐ Injecting drug user (IDU) ☐ MSM and IDU ☐ Heterosexual contact ☐ Heterosexual contact and IDU ☐ Hemophilia/coagulation disease or receipt of blood products ☐ Undetermined/unknown, risk not reported ☐ Perinatal transmission ☐ Other: Specify: ☐ Not documented in chart
2.5 Zip code client residing in on 3/1/01 (or first entry In review period)	_____ City, if no zip code indicated: ☐ Not documented In chart

2.6.a	Client health insurance on 3/1/01 (or first entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

List of Maryland's HealthChoice Medicaid MCOs

AMERICAID Community Care
Helix Family Choice
Jai Medical Systems
Maryland Physicians Care
Priority Partners
United HealthCare

2.6.b	Client health insurance on 2/28/02 (or last entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

2.7.a	HIV-disease status on 3/1/01 (or first entry in review period)	☐ HIV-positive, not AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ Not documented in chart
2.7.b	HIV-disease status on 2/28/02 (or last entry in review period)	☐ Deceased Date of death: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-positive, not AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart

2.8.a	CD4/Viral Load 3/1/01 (or first entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/specify:
2.8.b	CD4/Viral Load 2/28/02 (or last entry in review period)	CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/specify:
2.9.a	Client on HAART 3/1/01 (or first entry in review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/specify:
2.9.b	Client on HAART 2/28/02 (or last entry In review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/specify:

Section 3. Compliance with Case Management Adherence Service Standards

Instructions:
The client record should be reviewed only for the period March 1, 2001 to February 28, 2002. Only those phases of case management adherence which occurred during this review period should be reviewed by the reviewer.

3.1 Phase 1: Consumer/Client identification

"To determine if an individual is eligible for services by virtue of pre-established criteria developed by the service provider." [*CM Standard 2.1]*

☐ Initial client contact with agency for case management adherence services was during review period (3/1/01-2/28/02)
▶ GO TO 3.1.a, below

☐ Initial client contact with agency for case management adherence services was before 3/1/01
▶ GO TO 3.2, p. 6

3.1.a Why was client was referred for case management adherence services? (Check all that apply)

☐ Number of missed medical appointments
☐ Difficulty adhering to treatment regimen; evidenced by (specify): _____
☐ Initiating HAART therapy
☐ Changing HAART regimen
☐ Client request for adherence support
☐ Physician request for adherence support
☐ Pregnancy
☐ Reason for referral/need for adherence services not documented in chart
☐ Other/Specify:

3.1.b Who referred client into adherence program?

Internal referral:
- ☐ medical personnel
- ☐ case manager
- ☐ pharmacist
- ☐ outreach worker
- ☐ other personnel/specify:

External referral:
- ☐ personnel/specify:
- ☐ manager/specify:
- ☐ pharmacist
- ☐ outreach worker
- ☐ other personnel/specify:

☐ Medicaid MCO case manager
☐ Client/self-referral
☐ Referring person/agency not documented in chart
☐ Other/Specify:

3.1.c Was client receiving case management services prior to being assigned to case management adherence?

☐ Yes

❶ Was case management provided?

☐ By this agency.
☐ By another agency.
☐ Chart does not provide this information.

❷ Is client?

☐ Maintaining previous case manager.
☐ Being assigned a new client care facilitator at this agency.
☐ Chart does not provide this information.

☐ No
☐ Chart does not provide this information.

3.2 Phase 2: Intake

"To formally enter an eligible consumer/client into the system for further assessment and the development of the client's plan of care, it is necessary to collect all information about the consumer/client for subsequent planning, intervention and/or intake." *[CM Standard 2.2]*

☐ Client completed intake during review period (3/1/01 – 2/28/02)
▶ GO TO 3.2.a, below

☐ Client completed intake before review period (before 3/1/01)
▶ GO TO 3.3, p. 8

	Review Item	Documentation
3.2.a	Level of Case Management Adherence services client received during review period	☐ Intensive ☐ Intermediate/Periodic ☐ Multiple levels: Client reassessed to a different level of service during the review period. ☐ Client record does not adequately document level of case management adherence services.
3.2.b	Agency shall complete an initial assessment on eligible clients at time of intake; collecting all information outlined on agency's intake forms. *[CM Standard 2.2a]*	☐ Yes, initial assessment completed; intake forms completed. ☐ No, chart does not contain evidence assessment/intake forms were completed.

3.2.c	Clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment. *[CM Standard 2.2b]* *Emergency needs are defined as needs that will have serious immediate consequences for the client unless these needs are met.*	☐ Yes, client presented with emergency need, which was addressed by the conclusion of the intake appointment. ☐ No, client presented with emergency need, but this need was not addressed by the conclusion of the intake appointment. ☐ This standard not applicable to this client's situation; specify: ☐ Client did not present with an emergency need at time of intake ☐ Other: Specify:
3.2.d	Client will be seen for first case management adherence appointment within 5 working days after assignment to a client care facilitator. Clients requiring an off-site visit must be seen within 10 working days after assignment to client care facilitator. Exceptions are made if client initiates cancellation. *[CM Standard 2.2c]*	❶ Date of receipt of referral/identification: _____ ☐ Date not documented in chart ❷ Date client assigned to client care facilitator: _____ ☐ Date not documented in chart ❸ Date of first case management adherence appointment: _____ ☐ Date not documented in chart ❹ Was client seen within the specified time frame? ☐ Yes, client was seen within specified time frame. ☐ No, client was not seen within specified time frame. ☐ Information not provided. ☐ Other: Specify:
3.2.e	Agency shall assist the client in identifying and making an appointment with a medical provider for those not already connected to a primary medical care provider. *[CM Standard 2.2d]* *Client is to schedule his/own own appointment if able.*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met. ☐ This standard not applicable to this client's situation; specify: ☐ Client already connected to primary medical care provider ☐ Other: Specify:

3.3 Phase 3: Psychosocial needs assessment /Resource identification

☐ Client completed needs assessment during review period (3/1/01 – 2/28/02)
▶ GO TO 3.3.a, below

☐ Client completed needs assessment before review period (before 3/1/01)
▶ GO TO 3.4, p. 11

3.3.a
❶ Does the chart contain an assessment of client barriers to adherence? (This may be separate from or included in the client's case management assessment.)

☐ Yes; assessment of client barriers to adherence completed.
☐ No; no assessment of client barriers to adherence completed. ▶ GO TO 3.3.b, below

❷ Who completed the client barriers to adherence? (Check all that apply.)
☐ Nurse
☐ Case manager/Client Care Facilitator
☐ Other/Specify:
☐ Information not provided.

	Review item	Documentation
3.3.b	Client care facilitator shall complete a comprehensive written psychosocial needs assessment for each client within 30 days or by the conclusion of the 3rd case management adherence visit, whichever comes first. The needs assessment shall include a medical/psychosocial history and shall be included in the client record. *[CM Standard 2.3.a]*	❶ Date of completion of written needs assessment: _____ ☐ Date not documented in chart ❷ Number of case management adherence visits provided by the completion of written needs assessment: _____ ☐ Number of visits not documented in chart ❸ Was needs assessment completed within the specified time frame? ☐ Yes, written needs assessment completed within the specified time period. ☐ No ▸▸ *[indicate reason]* ☐ written needs assessment not completed within the specified time period ☐ written needs assessment not contained in chart ☐ Other/specify: ☐ Information not provided. 3.3.b continued ⇢

⇢ 3.3.b continued

❹ Check areas contained in assessment:

- ☐ Presenting problem
- ☐ Living situation
- ☐ Financial status/entitlement(s)
- ☐ Health insurance
- ☐ Substance abuse history
- ☐ Mental health history
- ☐ Current health status/symptoms
- ☐ Medical history
- ☐ Current medications
- ☐ Recent CD4
- ☐ Recent viral load
- ☐ Current medical needs (access to care, access to medications)
- ☐ Primary medical care provider history
- ☐ Nutrition
- ☐ Transportation
- ☐ Child care needs
- ☐ Employment history
- ☐ Legal history/issues
- ☐ Family composition
- ☐ Recreational/social activities
- ☐ Social/community supports
- ☐ Family composition
- ☐ Physical/sexual abuse history
- ☐ Awareness of safer sex practices

3.3.c	Client care facilitator shall ensure that client chart contains written indication that current needs have been discussed and/or identified at time of needs assessment *[CM Standard 2.3.a]* Client care facilitator should review the listed areas of consumer/client needs when performing needs assessment *[CM Standard 2.3.a]*	☐ Yes, chart documents that needs were discussed with client. ☐ No, chart does not contain evidence that standard was met. ☐ Other: Specify:

3.3.d Components of assessment of client barriers to adherence

Instructions: Complete the table below, based on the information contained in the assessment of client barriers to adherence.

☐ Check here if the chart does not contain an assessment of client barriers to adherence.

	Area contained in client assessment	Area	If assessed, was area identified as a need/barrier?
a	☐ Yes ☐ No	Depression	☐ Yes ☐ No
b	☐ Yes ☐ No	Other mental health issues	☐ Yes ☐ No
c	☐ Yes ☐ No	Belief of ability to adhere	☐ Yes ☐ No
d	☐ Yes ☐ No	Ability/belief of ability to fit medications into lifestyle	☐ Yes ☐ No
e	☐ Yes ☐ No	Belief that medications will improve health	☐ Yes ☐ No
f	☐ Yes ☐ No	Understanding the relationship between adherence and viral load	☐ Yes ☐ No
g	☐ Yes ☐ No	Understanding of the medication regimen	☐ Yes ☐ No
h	☐ Yes ☐ No	Fear of side effects	☐ Yes ☐ No
i	☐ Yes ☐ No	Current side effects from medications	☐ Yes ☐ No
j	☐ Yes ☐ No	Experience with medical appointment compliance	☐ Yes ☐ No
k	☐ Yes ☐ No	Experience with refilling medications	☐ Yes ☐ No
l	☐ Yes ☐ No	Experience with taking medications	☐ Yes ☐ No
m	☐ Yes ☐ No	Client level of trust with primary medical provider	☐ Yes ☐ No
n	☐ Yes ☐ No	Client level of trust with other health care team members	☐ Yes ☐ No
o	☐ Yes ☐ No	Client level of communication with primary medical provider	☐ Yes ☐ No
p	☐ Yes ☐ No	Client level of communication with other health care team members	☐ Yes ☐ No
q	☐ Yes ☐ No	Past alcohol use	☐ Yes ☐ No
r	☐ Yes ☐ No	Current alcohol use	☐ Yes ☐ No
s	☐ Yes ☐ No	Past illicit drug use	☐ Yes ☐ No
t	☐ Yes ☐ No	Current illicit drug use	☐ Yes ☐ No
u	☐ Yes ☐ No	Lack of insurance coverage for medication	☐ Yes ☐ No
v	☐ Yes ☐ No	Transportation	☐ Yes ☐ No
w	☐ Yes ☐ No	Child care	☐ Yes ☐ No
x	☐ Yes ☐ No	Medical provider hours/convenience/accessibility	☐ Yes ☐ No
y	☐ Yes ☐ No	Language barriers	☐ Yes ☐ No
z	☐ Yes ☐ No	Other/Specify:	☐ Yes ☐ No
@	☐ Yes ☐ No	Other/Specify:	☐ Yes ☐ No
#	☐ Yes ☐ No	Other/Specify:	☐ Yes ☐ No
%	☐ Yes ☐ No	Other/Specify:	☐ Yes ☐ No

4.0 Phase 4: Development of plan of care

"With the active participation of the consumer/client and possibly others, e.g., partners, parents, guardians, medical care givers, the [Client Care Coordinator] shall develop an appropriate course of action to access the identified resources required to met the needs and resolve the problems." *[CM Standard 2.4]*

☐ Client completed adherence intervention plan during review period (3/1/01 – 2/28/02)

▶ CONTINUE

☐ Client completed adherence intervention plan before review period (before 3/1/01)

▶ GO TO 3.5, p. 14

	Review item	Documentation
3.4.a	Client care facilitator shall, with active participation of client, identify which needs are to be addressed through the development of goals and objectives. Establish time frames for meeting goals and resolving the problem. Incorporate written objectives and goals into the plan of care, which is a permanent part of the client chart. *[CM Standard 2.4.a]*	Does the chart contain an adherence intervention plan? ☐ Yes, adherence intervention plan completed. ▶ Does action plan contain? (check all that apply) ☐ Defined goals ☐ Time-phased objectives ☐ Identified resources ☐ Client signature ☐ Client care facilitator signature ☐ No, plan of care was not completed.
3.4.b	Development of the plan of care should be started by the 3rd case management adherence visit or within 30 working days from the date of assignment to a client care facilitator. *[CM Standard 2.4.a]*	❶ Date of initiation of development of adherence intervention plan: _____ ☐ Date not documented in chart ❷ Number of case management adherence visits provided by the initiation of development of adherence intervention plan: _____ ☐ Number of visits not documented in chart ❸ Was adherence intervention plan completed within the specified time frame? ☐ Yes. ☐ No ▸▸ *[indicate reason]* ☐ adherence intervention plan not completed within the specified time period ☐ adherence intervention plan not contained in chart ☐ Other/specify: ☐ Information not provided.

3.4.c	All plans of care should be signed and dated by both the client and client care facilitator. *[CM Standard 2.4.c]*	Is the adherence intervention plan signed and dated by both the provider and the client? Signed: Provider: ☐ Yes ☐ No Dated : Provider: ☐ Yes ☐ No Signed: Client: ☐ Yes ☐ No Dated : Client: ☐ Yes ☐ No ☐ No; Client does not have case management plan of care.
3.4.d	Agency, together with client, shall identify appropriate resources needed to attain stated goals and objectives. Resources shall be written into plan of care. *[CM Standard 2.4.b]*	☐ Yes, resources are stated/identified in the adherence intervention plan. ☐ No, resources are not stated/identified in the adherence intervention plan. ☐ No; client does not have adherence intervention plan

Components of client adherence intervention plan

Check areas/interventions included in the client's adherence intervention plan

☐ Check here if the chart does not contain a client adherence intervention plan.

Client co-morbidities interventions
☐ Referral for mental health/psychiatric assessment and/or treatment
☐ Referral for alcohol/substance use assessment and/or treatment
☐ Other/specify:
☐ Other/specify:
Client education and skills-building interventions
☐ Working with client to design dosing schedule that fits client routine/lifestyle.
☐ Identification of potential reasons for missed doses and strategies to address them.
☐ Practice pill-taking with mock medications (e.g., jellybeans).
☐ Education about the relationship between antiretroviral therapy and viral load.
☐ Education about the consequences of non-adherence.
☐ Education about what to do if dose is missed and/or late.
☐ Education about the regimen and strategies to remember (e.g., daily calendar, pill boxes).
☐ Education about anticipated side effects and side effect management.
☐ Education/skills-building around disclosure issues.
☐ Other/specify:
☐ Other/specify:
☐ Other/specify:
Patient support interventions
☐ Linkage to peer advocate or mentor.
☐ Linkage to home nursing care for adherence-related visits.
☐ Telephone calls (or other contacts) to see how client is doing on new/modified regimen.
☐ Telephone calls (or other contacts) to remind client of scheduled medical appointments.
☐ Tracking of client medication refill dates and reminder calls to clients to refill prescription.
☐ Filling patient's pill box on a regular basis.
☐ Providing client a timer, watch, or other method to remind client.
☐ Peer support group.
☐ Coordination with other family members' medical and treatment regimens.
☐ Address language barriers through use of translator, interpreters, etc.
☐ Other/specify:
☐ Other/specify:
☐ Other/specify:
Access interventions
☐ Assistance in obtaining MADAP or other pharmaceutical assistance to assure continuity.
☐ Improve access to pharmaceuticals (on-site refills, interim doses, etc.).
☐ Reminder calls prior to appointments and to identify specific barriers/needs.
☐ Referrals for transportation, child care, or other services needed to attend appointments.
☐ Identification of more accessible provider.
☐ Coordination with other family members' medical and treatment regimens.
☐ Address language barriers through use of translator, interpreters, etc.
☐ Reviewing patient's pharmacy records for adherence.
☐ Other/specify:
☐ Other/specify:
☐ Other/specify:

3.5 Phase 5: Implementation and coordination of plan of care

▶ This section is to be completed for all clients

3.5.a	Client care coordinator shall proactively attempt to contact client after the development of the plan to implement those parts that were not executed at the time of plan development. Plan will establish priorities among the identified needs. *[CM Standard 2.5.a]*	☐ Yes, chart contains documentation that client care coordinator contacted client to implement the adherence intervention plan. ☐ No, chart does not contain documentation of contact.
3.5.b	Client care coordinator shall advise the client on making arrangements with service providers selected and on ways of gaining access to those services. *[CM Standard 2.5.b]*	☐ Yes, chart contains documentation that client care coordinator contacted advised client on service access issues. ☐ No, chart does not contain documentation that client care coordinator contacted advised client on service access issues.
3.5.c	Client care coordinator shall document in writing all **referrals**. *[CM Standard 2.5.c]*	☐ Yes, chart contains documentation on referrals. ☐ No, chart does not contain documentation on referrals.
3.5.d	Client care coordinator shall document in writing all **outcomes** of referrals. *[CM Standard 2.5.c]*	☐ Yes, chart contains documentation on outcomes. ☐ No, chart does not contain documentation on outcomes.
3.5.e	Any corresponding actions initiated by the client/other identified people and the outcomes resulting from these actions shall be incorporated into the client record. *[CM Standard 2.5.c]*	☐ Yes, chart contains documentation on actions initiated by the client/other identified people and these outcomes. ☐ No, chart does not contain on actions initiated by the client/other identified people and these outcomes.

3.6 Phase 6: Monitoring the Plan

Client care coordinator shall monitor the goals and objectives contained in the client plan to decide what steps need to take, if any.

▶ This section is to be completed for all clients

	Review item	Documentation
3.6.a	Documentation of the monitoring process shall be recorded in the client record. *[CM Standard 2.6.a]*	☐ Yes, chart contains evidence that minimum monitoring contacts were made. ☐ No, chart does not contain evidence that minimum monitoring contacts were made. ☐ Information not provided Monitoring shall occur at a minimum of the following: (Check level(s) received during review period) ☐ **Intensive case management adherence:** - A minimum of 1 contact per month - 1 face-to-face contact every 6 months ☐ **Intermediate/periodic case management adherence** - Case manager initiates a minimum of 1 contact every 3 months - 1 face-to-face contact every 6 months
3.6.b	Client care coordinator shall monitor the services provided and the services delivery to verify that the services are being received and are sufficient in quality and quantity. *[CM Standard 2.6.c]*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.
3.6.b	Client care coordinator shall provide written documentation (progress notes) of any difficulties encountered in achieving the goals and objectives and provide written strategies for resolving these difficulties. *[CM Standard 2.6.c]*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.
3.6.c	If a client cannot be located after several attempts to reach by telephone and/or letter, for 2 months, then a referral is made to case finding to assist in locating the client. *[CM Standard 2.6.a]*	☐ Yes, chart documents referral to case finding because attempts to contact have been unsuccessful. ☐ No, chart does not document referral to case finding after unsuccessful attempts to contact client. ☐ This standard not applicable to this client's situation; specify: ☐ Level of client contact appropriate, referral to case finding not required. ▶ GO TO 3.7, p. 16 ☐ Other: Specify:

3.6.d	If the client cannot be located within 90 days, the case management adherence record is moved to inactive status. *[CM Standard 2.6.a]*	☐ Yes, chart contains evidence that record was moved to inactive status after 90 days of unsuccessful attempts to contact client. ☐ No, chart does not contain evidence that record was moved to inactive status after 90 days of unsuccessful attempts to contact client. ☐ This standard not applicable to this client's situation; specify: ☐ Client located within 90 day time period, movement to inactive status not necessary. ▸ GO TO 3.7 below ☐ Other: Specify:
3.6.e	At end of year, if there is no contact, then the case management adherence record is closed. *[CM Standard 2.6.a]*	☐ Yes, chart contains evidence that case management adherence record was closed at the end of the year of no client contact. ☐ No, chart does not contain evidence that case management adherence record was closed at the end of the year of no client contact. ☐ This standard not applicable to this client's situation; specify: ☐ Client located; movement to closure status not necessary. ☐ Other: Specify:

3.7 Phase 7: Re-evaluation of the plan of care

"To review the success of the implementation of the plan of care and to determine if the client's needs have significantly changed; if needs have changed, then a new client plan shall be developed; if the needs are the same, then the current plan is continued for 1 year." *[CM Standard 2.7]*
"Evaluation of the implementation plan should be performed periodically, quarterly" *[CMA Standard IV.4]*

▸ This section is to be completed for all clients

Instructions: This section should be completed for all clients to assess the implementation (phase 5), monitoring (phase 6) and re-evaluation (phase 7)of the adherence intervention plan. Information should be abstracted on a quarterly basis:

- **Quarter 1**: March 1, 2001 to May 31, 2001;
- **Quarter 2**: June 1, 2001 to August 31, 2001;
- **Quarter 3**: September 1, 2001 to November 30, 2001; and
- **Quarter 4**: December 1, 2001 to February 28, 2002.

Note: If there are multiple visits/values for the quarter, then record data from the last visit/value for that quarter, unless instructed otherwise.

Quarter 1: March 1, 2001 to May 31, 2001

☐ Client was an active client during this quarter. ▶ Complete this section
☐ Client was enrolled in adherence services after this quarter. ▶ GO TO Quarter 2, p. 20

❶ Appointment adherence Qrt 1: March 1, to May 31, 2001

Based on review of the client record, record the number of visits made and/or missed during the quarter. Also document whether transportation and child care were arranged and/or if client was reminded in advance of the appointment with a reminder phone call or other method.

Appointment type	# Appointments Scheduled	# Appointments Made	# Appointments Missed	Transportation	Child care	Reminder call	Appointment history not documented in chart
Medical care				☐	☐	☐	☐ not documented in chart
Case management adherence				☐	☐	☐	☐ not documented in chart
Counseling				☐	☐	☐	☐ not documented in chart
Substance abuse				☐	☐	☐	☐ not documented in chart
Mental health				☐	☐	☐	☐ not documented in chart
Other/specify:				☐	☐	☐	☐ not documented in chart

❷ Multidisciplinary team meetings Quarter 1: March 1, 2001 to May 31, 2001

▶ Were any multi-disciplinary team (more than one discipline) meetings held during the quarter to discuss the patient's care?

☐ Yes.
☐ No.
☐ Information not provided.

❸ Medical status and treatment_ Qrt 1: March 1, to May 31, 2001

Laboratory values Record latest value for the quarter if there is more than one value.

CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ CD4 testing during this quarter not documented in chart	Viral load: _____ Date of test: ___/___/ _____ ☐ Viral load testing during this quarter not documented in chart

Antiretroviral regimen Qrt 1: March 1, to May 31, 2001

☐ Patient is not on antiretroviral therapy.
☐ Patient is on antiretroviral therapy, but current regimen is not documented in chart.
List antiretroviral therapy patient is taking at the **beginning** of the quarter (Note: if a combination agent is used (e.g., Combivir, trizivir), note the agent, not its components):

Medication	Dose	Frequency	For coding purposes only

▶ Is patient also taking medications for prevention (e.g., DS TMP-SX {Bactrim}, Clarithromycin, Valganciclovir) ?

☐ Yes ☐ No ☐ Updated/current medications not documented In chart

▶ During the quarter, was the patient's antiretroviral regimen changed from the regimen prescribed at the beginning of the quarter? ☐ Yes ☐ No

▶▶ I f YES, indicate the documented reason for this change: (Check all that apply)
☐ Reason is not documented in the chart
☐ Patient request
☐ Toxicity
☐ Description of side effects
☐ Suboptimal virologic response
☐ Documented resistance (e.g., use of resistance testing indicates that current regimen is resistant)
☐ Other/specify:

❹ Assessment of Adherence Qrt 1: March 1, to May 31, 2001

▶ Does the chart contain documentation of assessment of the patient's adherence with medications?

☐ Yes

⏩ I f YES, indicate the documented methods used by the provider(s):

☐ Patient self report
☐ Pill counting by provider
☐ Data from MEMS (electronic adherence monitoring)
☐ Review of pharmacy records
☐ Side effects
☐ Other/Specify:

☐ No

❺ Assessment and identification of new barriers or co-morbidities Qrt 1: March 1, to May 31, 2001

▶ Did the adherence team assess for any new barriers or co-morbidities to adherence during the quarter?

☐ No; chart does not indicate that an assessment was made during the quarter.
☐ Yes; chart indicates that an assessment was made.

⏩ Were new barriers or co-morbidities identified?

☐ No new barriers or co-morbidities identified
☐ Yes; new barriers or co-morbidities identified: Specify:

❻ Evaluation of adherence intervention plan Qrt 1: March 1, to May 31, 2001

▶ Does the chart document evaluation of the implementation plan during the quarter?

☐ No; chart does not document evaluation of the implementation plan during the quarter.
☐ Yes; chart indicates that evaluation of the implementation plan was made.

⏩ Was client involved in this assessment?

☐ Yes
☐ No

⏩ Based on documentation in the chart, should this evaluation have led to the development of new goals/objectives/outcomes in the adherence intervention plan?

☐ Yes, adherence intervention plan needed to be updated.

►Was adherence intervention plan?

☐ Updated; new goals/objectives/outcomes established as indicated.
☐ Not updated as indicated by the evaluation.

►Did client sign this update?

☐ Yes
☐ No

☐ No, initial adherence intervention plan content was still appropriate based on the evaluation.

Quarter 2: June 1, 2001 to August 31, 2001

☐ Client was an active client during this quarter. ▶ Complete this section
☐ Client was enrolled in adherence services after this quarter. ▶ GO TO Quarter 3, p. 23

❶ Appointment adherence Qrt 2: June 1, to August 31, 2001

Based on review of the client record, record the number of visits made and/or missed during the quarter. Also document whether transportation and child care were arranged and/or if client was reminded in advance of the appointment with a reminder phone call or other method.

Appointment type	# Appointments Scheduled	# Appointments Made	# Appointments Missed	Transportation	Child care	Reminder call	Appointment history not documented in chart
Medical care				☐	☐	☐	☐ not documented in chart
Case management adherence				☐	☐	☐	☐ not documented in chart
Counseling				☐	☐	☐	☐ not documented in chart
Substance abuse				☐	☐	☐	☐ not documented in chart
Mental health				☐	☐	☐	☐ not documented in chart
Other/specify:				☐	☐	☐	☐ not documented in chart

❷ Multidisciplinary team meetings Qrt 2: June 1, to August 31, 2001

▶ Were any multi-disciplinary team (more than one discipline) meetings held during the quarter to discuss the patient's care?

☐ Yes.
☐ No.
☐ Information not provided.

❸ Medical status and treatment Qrt 2: June 1, to August 31, 2001

Laboratory values Record latest value for the quarter if there is more than one value.

CD4 _____ cells/uL Date of test: ___/___/ _____ ☐ CD4 testing during this quarter not documented in chart	Viral load: _____ Date of test: ___/___/ _____ ☐ Viral load testing during this quarter not documented in chart

Antiretroviral regimen Qrt 2: June 1, to August 31, 2001

☐ Patient is not on antiretroviral therapy.
☐ Patient is on antiretroviral therapy, but current regimen is not documented in chart.
List antiretroviral therapy patient is taking at the **beginning** of the quarter (Note: if a combination agent is used (e.g., Combivir, trizivir), note the agent, not its components):

Medication	Dose	Frequency	For coding purposes only

▶ Is patient also taking medications for prevention (e.g., DS TMP-SX {Bactrim}, Clarithromycin, Valganciclovir) ?

☐ Yes ☐ No ☐ Updated/current medications not documented In chart

▶ During the quarter, was the patient's antiretroviral regimen changed from the regimen prescribed at the beginning of the quarter? ☐ Yes ☐ No

▶▶ I f YES, indicate the documented reason for this change: (Check all that apply)
☐ Reason is not documented in the chart
☐ Patient request
☐ Toxicity
☐ Description of side effects
☐ Suboptimal virologic response
☐ Documented resistance (e.g., use of resistance testing indicates that current regimen is resistant)
☐ Other/specify:

❹ Assessment of Adherence — Qrt 2: June 1, to August 31, 2001

▶ Does the chart contain documentation of assessment of the patient's adherence with medications?

☐ Yes

▶▶ I f YES, indicate the documented methods used by the provider(s):

- ☐ Patient self report
- ☐ Pill counting by provider
- ☐ Data from MEMS (electronic adherence monitoring)
- ☐ Review of pharmacy records
- ☐ Side effects
- ☐ Other/Specify:

☐ No

❺ Assessment and identification of new barriers or co-morbidities — Qrt 2: June 1, to August 31, 2001

▶ Did the adherence team assess for any new barriers or co-morbidities to adherence during the quarter?

☐ No; chart does not indicate that an assessment was made during the quarter.

☐ Yes; chart indicates that an assessment was made.

▶▶ Were new barriers or co-morbidities identified?

- ☐ No new barriers or co-morbidities identified
- ☐ Yes; new barriers or co-morbidities identified: Specify:

❻ Evaluation of adherence intervention plan — Qrt 2: June 1, to August 31, 2001

▶ Does the chart document evaluation of the implementation plan during the quarter?

☐ No; chart does not document evaluation of the implementation plan during the quarter.

☐ Yes; chart indicates that evaluation of the implementation plan was made.

▶▶ Was client involved in this assessment?

- ☐ Yes
- ☐ No

▶▶ Based on documentation in the chart, should this evaluation have led to the development of new goals/objectives/outcomes in the adherence intervention plan?

☐ Yes, adherence intervention plan needed to be updated.

►Was adherence intervention plan?

- ☐ Updated; new goals/objectives/outcomes established as indicated.
- ☐ Not updated as indicated by the evaluation.

►Did client sign this update?

- ☐ Yes
- ☐ No

☐ No, initial adherence intervention plan content was still appropriate based on the evaluation.

Quarter 3: September 1, 2001 to November 30, 2001

☐ Client was an active client during this quarter. ▶ Complete this section
☐ Client was enrolled in adherence services after this quarter. ▶ GO TO Quarter 4, p. 26

❶ Appointment adherence Qrt 3: September 1, to November 30, 2001

Based on review of the client record, record the number of visits made and/or missed during the quarter. Also document whether transportation and child care were arranged and/or if client was reminded in advance of the appointment with a reminder phone call or other method.

Appointment type	# Appointments Scheduled	# Appointments Made	# Appointments Missed	Transportation	Child care	Reminder call	Appointment history not documented in chart
Medical care				☐	☐	☐	☐ not documented in chart
Case management adherence				☐	☐	☐	☐ not documented in chart
Counseling				☐	☐	☐	☐ not documented in chart
Substance abuse				☐	☐	☐	☐ not documented in chart
Mental health				☐	☐	☐	☐ not documented in chart
Other/specify:				☐	☐	☐	☐ not documented in chart

❷ Multidisciplinary team meetings Qrt 3: September 1, to November 30, 2001

▶ Were any multi-disciplinary team (more than one discipline) meetings held during the quarter to discuss the patient's care?

☐ Yes.
☐ No.
☐ Information not provided.

❸ Medical status and treatment Qrt 3: September 1, to November 30, 2001

Laboratory values Record latest value for the quarter if there is more than one value.

CD4 _____cells/uL Date of test: ___/___/ _____ ☐ CD4 testing during this quarter not documented in chart	Viral load: _____ Date of test: ___/___/ _____ ☐ Viral load testing during this quarter not documented in chart

Antiretroviral regimen Qrt 3: September 1, to November 30, 2001

☐ Patient is not on antiretroviral therapy.
☐ Patient is on antiretroviral therapy, but current regimen is not documented in chart.
List antiretroviral therapy patient is taking at the **beginning** of the quarter (Note: if a combination agent is used (e.g., Combivir, trizivir), note the agent, not its components):

Medication	Dose	Frequency	For coding purposes only

▶ Is patient also taking medications for prevention (e.g., DS TMP-SX {Bactrim}, Clarithromycin, Valganciclovir) ?

☐ Yes ☐ No ☐ Updated/current medications not documented In chart

▶ During the quarter, was the patient's antiretroviral regimen changed from the regimen prescribed at the beginning of the quarter? ☐ Yes ☐ No

▶▶ I f YES, indicate the documented reason for this change: (Check all that apply)
☐ Reason is not documented in the chart
☐ Patient request
☐ Toxicity
☐ Description of side effects
☐ Suboptimal virologic response
☐ Documented resistance (e.g., use of resistance testing indicates that current regimen is resistant)
☐ Other/specify:

❹ Assessment of Adherence — Qrt 3: September 1, to November 30, 2001

▶ Does the chart contain documentation of assessment of the patient's adherence with medications?

☐ Yes

⏩ I f YES, indicate the documented methods used by the provider(s):

☐ Patient self report
☐ Pill counting by provider
☐ Data from MEMS (electronic adherence monitoring)
☐ Review of pharmacy records
☐ Side effects
☐ Other/Specify:

☐ No

❺ Assessment and identification of new barriers or co-morbidities — Qrt 3: Sept. 1, to Nov. 30, 2001

▶ Did the adherence team assess for any new barriers or co-morbidities to adherence during the quarter?

☐ No; chart does not indicate that an assessment was made during the quarter.
☐ Yes; chart indicates that an assessment was made.

⏩ Were new barriers or co-morbidities identified?

☐ No new barriers or co-morbidities identified
☐ Yes; new barriers or co-morbidities identified: Specify:

❻ Evaluation of adherence intervention plan — Qrt 3: September 1, to November 30, 2001

▶ Does the chart document evaluation of the implementation plan during the quarter?

☐ No; chart does not document evaluation of the implementation plan during the quarter.
☐ Yes; chart indicates that evaluation of the implementation plan was made.

⏩ Was client involved in this assessment?

☐ Yes
☐ No

⏩ Based on documentation in the chart, should this evaluation have led to the development of new goals/objectives/outcomes in the adherence intervention plan?

☐ Yes, adherence intervention plan needed to be updated.

►Was adherence intervention plan?

☐ Updated; new goals/objectives/outcomes established as indicated.
☐ Not updated as indicated by the evaluation.

►Did client sign this update?

☐ Yes
☐ No

☐ No, initial adherence intervention plan content was still appropriate based on the evaluation.

Quarter 4: December 1, 2001 to February 28, 2002

▶ Complete this section for all clients

❶ Appointment adherence Qrt 4: December 1, 2001 to February 28, 2002

Based on review of the client record, record the number of visits made and/or missed during the quarter. Also document whether transportation and child care were arranged and/or if client was reminded in advance of the appointment with a reminder phone call or other method.

Appointment type	# Appointments Scheduled	# Appointments Made	# Appointments Missed	Transportation	Child care	Reminder call	Appointment history not documented in chart
Medical care				☐	☐	☐	☐ not documented in chart
Case management adherence				☐	☐	☐	☐ not documented in chart
Counseling				☐	☐	☐	☐ not documented in chart
Substance abuse				☐	☐	☐	☐ not documented in chart
Mental health				☐	☐	☐	☐ not documented in chart
Other/specify:				☐	☐	☐	☐ not documented in chart

❷ Multidisciplinary team meetings Qrt 4: December 1, 2001 to February 28, 2002

▶ Were any multi-disciplinary team (more than one discipline) meetings held during the quarter to discuss the patient's care?

☐ Yes.
☐ No.
☐ Information not provided.

❸ Medical status and treatment — Qrt 4: December 1, 2001 to February 28, 2002

Laboratory values Record latest value for the quarter if there is more than one value.

CD4 _____cells/uL Date of test: ___/___/ _____ ☐ CD4 testing during this quarter not documented in chart	Viral load: _____Date of test: ___/___/ _____ ☐ Viral load testing during this quarter not documented in chart

Antiretroviral regimen Qrt 4: December 1, 2001 to February 28, 2002

☐ Patient is not on antiretroviral therapy.
☐ Patient is on antiretroviral therapy, but current regimen is not documented in chart.
List antiretroviral therapy patient is taking at the **beginning** of the quarter (Note: if a combination agent is used (e.g., Combivir, trizivir), note the agent, not its components):

Medication	Dose	Frequency	For coding purposes only

▶ Is patient also taking medications for prevention (e.g., DS TMP-SX {Bactrim}, Clarithromycin, Valganciclovir) ?

☐ Yes ☐ No ☐ Updated/current medications not documented In chart

▶ During the quarter, was the patient's antiretroviral regimen changed from the regimen prescribed at the beginning of the quarter? ☐ Yes ☐ No

▶▶ I f YES, indicate the documented reason for this change: (Check all that apply)
☐ Reason is not documented in the chart
☐ Patient request
☐ Toxicity
☐ Description of side effects
☐ Suboptimal virologic response
☐ Documented resistance (e.g., use of resistance testing indicates that current regimen is resistant)
☐ Other/specify:

❹ Assessment of Adherence — Qrt 4: December 1, 2001 to February 28, 2002

▶ Does the chart contain documentation of assessment of the patient's adherence with medications?

☐ Yes

▶▶ I f YES, indicate the documented methods used by the provider(s):

☐ Patient self report
☐ Pill counting by provider
☐ Data from MEMS (electronic adherence monitoring)
☐ Review of pharmacy records
☐ Side effects
☐ Other/Specify:

☐ No

❺ Assessment and identification of new barriers or co-morbidities — Qrt 4: Dec. 1, 2001 to Feb. 28, 2002

▶ Did the adherence team assess for any new barriers or co-morbidities to adherence during the quarter?

☐ No; chart does not indicate that an assessment was made during the quarter.
☐ Yes; chart indicates that an assessment was made.

▶▶ Were new barriers or co-morbidities identified?

☐ No new barriers or co-morbidities identified
☐ Yes; new barriers or co-morbidities identified: Specify:

❻ Evaluation of adherence intervention plan — Qrt 4: December 1, 2001 to February 28, 2002

▶ Does the chart document evaluation of the implementation plan during the quarter?

☐ No; chart does not document evaluation of the implementation plan during the quarter.
☐ Not applicable; client initiated services during this quarter and received services for less than 3 months.
☐ Yes; chart indicates that evaluation of the implementation plan was made.

▶▶ Was client involved in this assessment?

☐ Yes
☐ No

▶▶ Based on documentation in the chart, should this evaluation have led to the development of new goals/objectives/outcomes in the adherence intervention plan?

☐ Yes, adherence intervention plan needed to be updated.

►Was adherence intervention plan?

☐ Updated; new goals/objectives/outcomes established as indicated.
☐ Not updated as indicated by the evaluation.

►Did client sign this update?

☐ Yes
☐ No

☐ No, initial adherence intervention plan content was still appropriate based on the evaluation.

3.8 Phase 8: Closure

▶ This section is to be completed for all clients

	Review item	Documentation
3.8.a	Continuing eligibility for Case Management Adherence services	During the review period, was the client found to be no longer eligible for case management adherence services? ☐ Yes, client determined **not to meet** eligibility criteria. ▶ Was case management adherence case closed? ☐ **Yes,** case management adherence file closed. ☐ **No,** client continued to receive services. ☐ No, client continued to be eligible to receive services. ▶ Go To: Section 4.0, p. 30
3.8.b	Reason for closure	Check applicable reason for closure: ☐ At the request of the client. ☐ Client terminated by agency from service. ☐ Lack of client contact. ☐ Due to client death. ☐ Client relocated out of service area. ☐ Client case management adherence services transferred to another case management adherence services agency. ☐ Client case management adherence services terminated, but client transferred to case management services: ☐ At same agency. ☐ At a different agency. ☐ Reason for closure not documented. ☐ Other: specify
3.8.c	Prior to closure (with the exception of death), the agency shall attempt to inform the client of the re-entry requirements into the system, and make explicit what case closing means to the client. *[CM Standard 2.8.a]*	☐ Yes, chart contains documentation that appropriate notification was provided. ☐ No, chart does not contain evidence that standard was met. ☐ Not applicable; client deceased; notification not required.
3.8.d	The agency shall close a client file according to the procedures established by the agency. *[CM Standard 2.8.b]*	☐ Yes, chart contains evidence that standard was met. ☐ No, chart does not contain evidence that standard was met.

Section 4. Service Outcomes

Instructions:

This section should be completed only for clients who had an action plan during the review period. Reviewers are asked to determine:

A) whether an unmet need was identified during the intake/assessment in 7 areas (income assistance, health insurance, housing, primary health care provider, substance abuse treatment services, emotional counseling, and transportation), and, if the unmet need was identified, then determine;
B) whether a goal to meet this unmet need was established in the action plan;
C) whether the chart contains documentation relating to case management adherence activities performed to meet this unmet need; and
D) whether the unmet need was met.

▶ If the chart does not contain a client plan, check here: ☐ ■END OF CHART REVIEW

4.1 **Income Assistance** Definition of unmet need: • Being unemployed; and/or • Not receiving any public assistance (SSI, SSDI, TANF) Definition of met need: • Being employed; and/or • Receiving some public assistance (SSI, SSDI, TANF)	A. Was unmet need for income assistance identified in latest assessment? ☐ Yes ☐ No ▶GO TO 4.2 ☐ No intake/assessment in chart ▶GO TO 4.2 B. Was goal established in latest plan to address need for income assistance? ☐ Yes ☐ No C. Is there documentation in chart relating to case management adherence activities performed to address the need for income assistance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for income assistance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.2 **Health insurance** Definition of unmet need: • Having no health insurance; and/or • Having inadequate insurance to meet needs (e.g., medications) • Experiencing difficulty obtaining referrals/assignment to HIV primary care and/or specialty providers from MCO Definition of met need: • Having a form of health insurance; and/or • Having insurance to meet unmet need (e.g., MADAP) • Obtaining necessary referrals/assignment to HIV primary care and/or specialty providers from MCO	A. Was unmet need for health insurance identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.3 ☐ No intake/assessment in chart ▶ GO TO 4.3 B. Was goal established in latest plan to address need for health insurance? ☐ Yes ☐ No C. Is there documentation in chart relating to case management adherence activities performed to address the need for health insurance? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for health insurance met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.3 **Housing** Definition of unmet need: • Being unstably housed; or • Living in shelter; SRO; doubled-up with friend/relative; hospital-nursing home-residential care facility and medically ready for discharge; or • Living in situation other than ones own house, apartment, supported living Definition of met need: • Being stably housed • Living in ones own house, apartment, supported living	A. Was unmet need for housing identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.4 ☐ No intake/assessment in chart ▶ GO TO 4.4 B. Was goal established in latest plan to address need for housing? ☐ Yes ☐ No ☐ No plan in chart C. Is there documentation in chart relating to case management adherence activities performed to address the need for housing? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for housing met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.4 **Primary Health Care Provider** Definition of unmet need: • Not being able to Identify a primary health care provider/agency from whom the patient can receive routine, non-emergent care related to HIV disease and other health care needs Definition of met need: • Being able to Identify a primary health care provider/agency from whom the patient has received routine, non-emergent care related to HIV disease and other health care needs • Being able to report current CD4 count, viral load, treatment regimen	A. Was unmet need for a primary health care provider identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.5 ☐ No intake/assessment in chart ▶ GO TO 4.5 B. Was goal established in latest plan to address need for primary health care provider? ☐ Yes ☐ No ☐ No plan in chart C. Is there documentation in chart relating to case management adherence activities performed to address the need for primary health care provider? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for primary health care provider met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.5 **Substance Abuse Treatment Services** Definition of unmet need: • Self reported drug and /or alcohol use and/or dependence during period before Intake • Use of Illicit drugs/prescription drugs known to cause dependence • Use of more drugs than intended • Presence of emotional/psychiatric problem associated with drug use Definition of met need • Having received professional substance abuse services or participating in a self-help group	A. Was unmet need for substance abuse treatment identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.6 ☐ No intake/assessment in chart ▶ GO TO 4.6 B. Was goal established in latest plan to address need for substance abuse treatment services? ☐ Yes ☐ No ☐ No plan in chart C. Is there documentation in chart relating to case management adherence activities performed to address the need for substance abuse treatment services? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for substance abuse treatment services met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.6 **Emotional Counseling** Definition of unmet need: • Self reported. Definition of met need: • Having seen a mental health provider, attended a support group, or seen a spiritual provider.	A. Was unmet need for emotional counseling identified in latest assessment? ☐ Yes ☐ No ▶ GO TO 4.7 ☐ No intake/assessment in chart ▶ GO TO 4.7 B. Was goal established in latest plan to address need for emotional counseling? ☐ Yes ☐ No ☐ No plan in chart C. Is there documentation in chart relating to case management adherence activities performed to address the need for emotional counseling? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for emotional counseling met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

4.7 **Transportation/Health care-related** Definition of unmet need: • Self reported need for transportation to health care related appointments • History of missing health care related appointments due to lack of transportation to appointments Definition of met need: • Having transportation needs met; enabling compliance with health care related appointments.	A. Was unmet need for transportation/health care-related identified in latest assessment? ☐ Yes ☐ No ■ END OF CHART REVIEW ☐ No intake/assessment in chart ■ END OF CHART REVIEW B. Was goal established in most recent/latest plan to address need for transportation/health care-related? ☐ Yes ☐ No ☐ No plan in chart C. Is there documentation in chart relating to case management adherence activities performed to address the need for transportation/health care-related? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart D. Was the identified need for transportation/health care-related met? ☐ Yes ☐ No ☐ No progress notes or other documentation in chart

■ END OF CHART REVIEW

BCHD Quality Improvement Project
Case Management Adherence
Agency Survey

- Agency Name:
- Address:
- Person completing form:
- Telephone:
- Fax:
- E-mail:

Please check all of the services that your agency **directly provided,** on-site during Title I fiscal year 2001 (March 1, 2001-February 28, 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Please check all of the services that your agency does not directly provide on-site, but have **established (written) referral agreements** with other agencies to provide these services to your clients during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Mental Health Services
- ☐ Outreach
- ☐ Substance Abuse Treatment
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Standards of Care

A. Service Model

1. Which service model Is used to provide case management adherence services:

   ☐ **Model A:** Degreed Client Care Facilitator
   ☐ **Model B:** Degreed Client Care Facilitator ***and*** an HIV-positive Peer Counselor who has experience working with HIV-positive consumers and is able to appropriately model adherent behavior.
   ☐ **Other:** Specify

2. Identify the staff positions and the FTEs supported by Title I case management adherence funds.

Position	FTE (% of effort)

3. Identify the level of experience and educational background for ***each*** Degreed Client Care Facilitator supported by Title I case management adherence funds:

Name/Position	Experience/education
	☐ BSW and minimum of 5 years HIV experience ☐ MSW and minimum of 2 years HIV experience ☐ RN ☐ Other: Specify
	☐ BSW and minimum of 5 years HIV experience ☐ MSW and minimum of 2 years HIV experience ☐ RN ☐ Other: Specify

Name/Position	Experience/education
	☐ BSW and minimum of 5 years HIV experience ☐ MSW and minimum of 2 years HIV experience ☐ RN ☐ Other: Specify
	☐ BSW and minimum of 5 years HIV experience ☐ MSW and minimum of 2 years HIV experience ☐ RN ☐ Other: Specify

4. What is the average case load for case management adherence services?

   ☐ Less than 20 clients
   ☐ 20-24 clients
   ☐ 25-29 clients
   ☐ 30-35 clients
   ☐ More than 35 clients

5. How does the agency measure adherence to appointments?

   ☐ Consultation forms/feedback from medical provider
   ☐ Client self-report
   ☐ Adherence staff contacts medical provider staff
   ☐ Other: Specify

6. How does the agency measure adherence to antiretroviral therapies?

   ☐ Client self-report
   ☐ MEMS Caps
   ☐ Pharmacy records
   ☐ Pill counting
   ☐ Medical provider assessment
   ☐ Drug level assays
   ☐ CD4 count and/or viral load
   ☐ Other: Specify

7. What other support services are provided for clients enrolled in the case management adherence program?

   ☐ No additional support services are provided
   ☐ Child care
   ☐ Transportation
   ☐ Other: Specify

B. Licensing, Training and Supervision

8. Is the agency licensed by an appropriate body?

   ☐ Yes ☐ No

9. Where applicable, do staff have licenses that are current and appropriate for providing case management adherence services?

   ☐ Yes ☐ No

10. Are all supervisors of peer counselors licensed social workers or registered nurses?

    ☐ Yes ☐ No

11. Does the agency maintain documentation that demonstrates case management adherence services are provided directly by, or under supervision of, or in consultation with a licensed social worker and/or registered nurse?

    ☐ Yes ☐ No

12. Does the agency maintain documentation for all case management adherence staff of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS?

    ☐ Yes ☐ No

13. Does the agency have written policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis?

    ☐ Yes ☐ No

14. Does the agency have a system that regularly updates the staff of available services for people living with HIV/AIDS?

    ☐ Yes ☐ No

    ▸ If Yes, describe the system.

15. Does the agency have written policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis?

☐ Yes ☐ No

C. Practice

16. Does the agency have written policies regarding:

☐ Yes ☐ No a. Eligibility for service
☐ Yes ☐ No b. Timeframe for addressing emergency needs identified during intake
☐ Yes ☐ No c. Timeframe for scheduling of first case management adherence appointment
☐ Yes ☐ No d. Timeframe for completion of written psychosocial needs assessment
☐ Yes ☐ No e. Assessment/identification of medical status barriers/co-morbidities, and planned interventions
☐ Yes ☐ No f. Development of client adherence Intervention plan
☐ Yes ☐ No g. Timeframe for the development of client adherence intervention plan
☐ Yes ☐ No h. Review of adherence Intervention plan with client and signing and dating of service plan by staff and client
☐ Yes ☐ No i. Documentation of referrals and outcomes
☐ Yes ☐ No j. Quarterly evaluation of adherence intervention plan
☐ Yes ☐ No k. Timeframe for re-evaluation of client plan of care
☐ Yes ☐ No l. Timeframe for referral of clients lost to follow-up for case finding assistance
☐ Yes ☐ No m. Timeframe for moving client file to inactive status
☐ Yes ☐ No n. Timeframe for closure of case file
☐ Yes ☐ No o. Timeframe for completion and submission of Adherence Project reporting form

D. Client Record Closure

17. Have written procedures for closing client records been established?

☐ Yes ☐ No

- If Yes, describe the procedures.

18. Are records for adult clients (over 18 years) kept for a minimum of 10 years after last record entry?

☐ Yes ☐ No

19. Are records for children clients (under 19 years) archived until the child reaches the age of 24 or six years after death, if sooner?

☐ Yes ☐ No

E. Consumer/Client Rights and Responsibilities

20. Does the agency have written policies and procedures regarding:

☐ Yes	☐ No	Confidentiality
☐ Yes	☐ No	Grievance procedures
☐ Yes	☐ No	Release of information
☐ Yes	☐ No	System for ensuring case records are protected and secured
☐ Yes	☐ No	Client rights, responsibilities and agency expectations of each client
☐ Yes	☐ No	Voluntary and involuntary/disengagement from services

21. Are patients required to sign a statement indicating policies and procedures regarding confidentiality, grievance, eligibility and services were explained them?

☐ Yes ☐ No

F. Quality Improvement

22. Does the agency have an on-going quality improvement/quality assurance program for Case Management Adherence services that identifies areas for improvement and subsequent actions taken?

☐ Yes ☐ No

23. Does the agency have a process for clients to evaluate the agency, staff and services?

☐ Yes ☐ No

- If Yes, describe this process.

SERVICE CATEGORY: CASE MANAGEMENT
SUB-CATEGORY: ADHERENCE

revised September 2000, ratified January 2001

Guidance for Providers

Throughout the Baltimore Eligible Metropolitan Area, service providers experience consumers/clients/patients failing to keep appointments and/or follow through with planned medical regimens. The rate of no shows for appointment varies across the EMA, but some treatment services may have nearly 50% of their scheduled appointments not kept. Since failure to keep scheduled appointments, especially HIV medical care appointments, has a serious impact on the state of wellness of the individual, as well as causing a serious waste of limited staff and financial resources, the Greater Baltimore HIV Health Services Planning Council has designated funds to address adherence issues.

Standards for Case Management shall be used as service guidance for the provider agency/organizations and the staff delivering services.

Special Project on Adherence

I. STATEMENT OF ISSUES AND TARGET GROUP

Special Project to work with those HIV+ individuals who are known to the Ryan White Title I services continuum but who have identified problems with keeping appointments with the primary medical care provider. Individuals who keep health care appointments but who are not following the agreed upon treatment regimen are a target group for this project.

II. DEFINITION

The goal of the project is to provide intensive services directed toward identifying and remediating barriers that interfere with the consumer adhering to the needed medical services or following the planned medical treatments.

III. ELIGIBILITY

a. Those individuals who have missed medical or other related appointments in the past 12 months are eligible and individuals who are not following the planned medical regimen may be offered this service.
b. Referrals may be made from within the health care provider facility or from outside the health care provider facility or self-referral.

IV. LOCATION

a. Primary Medical Care Facility
b. Community-based agency
c. Substance Abuse or Mental Health Services Providers

V. SERVICE MODELS

The service model could include either of the following:
A.) a nurse, social worker, case manager; or
B.) a nurse, social worker, case manager partnered with trained peer counselor.

A. Degreed Client Care Facilitator with a minimum BSW and five (5) years HIV experience or an MSW with two (2) years HIV experience. Case load size between 30 and 35 active cases. Services include: intake, assessment, service planning, care coordination, follow-up, referral, and other interventions that lead to the goal of becoming fully adherent. Reporting on project is a major responsibility of the staff.

B. Degreed Client Care Facilitator with the same qualifications at Model A. A Peer Counselor will work with the Client Care Facilitator in providing the services to the clients. The Peer Counselor must be HIV positive, have experience working with HIV positive consumers and be able to appropriately model adherent behavior. The Peer counselor must have completed high school and completed training through a DHMH sponsored HIV training program(s). Services to be offered are the same in both models.

IV. Funds are provided within both models for support services for enrolled consumers.

1. Assessment of barriers to adherence is performed by the nurse, social worker or case manager working in the adherence program.
2. Adherence intervention plan must be developed with the consumer/client.

3. Clients must sign the intervention plan which may include contact with or from the peer counselor.
4. Evaluation of the implementation plan should be performed periodically, quarterly.

VII. REPORTING

At minimum the generated Adherence Project reporting form should include the following:

1) Medical Status
2) Barriers/Co-morbidities
3) Planned Interventions

These elements are additional to the elements of the agency's standard intake form.

The Adherence Project reporting form is required to be completed as appropriate and submitted periodically as the consumer progresses through his/her planned program.

Each funded agency must have a Quality Assurance (QA) Plan.

CATEGORY: CASE MANAGEMENT

ratified: October, 1998.

DEFINITION

Case management is defined as a discrete service through which multiple psychosocial service needs of clients are met in order to maximize continuity for quality care. Case management practice components include:

A. HEALTH-PSYCHOSOCIAL ASSESSMENT
B. CARE PLANNING
C. PROCUREMENT OF SERVICES
D. LINKAGE WITH SERVICES
E. DELIVERY OF SERVICES
F. ADVOCACY
G. ON-GOING MONITORING

CATEGORY: CASE MANAGEMENT

STANDARDS OF CARE 1.0

Case Management services are directed toward ensuring the timely and coordinated access to medically necessary and appropriate levels of care and support services that enhance continuity of care across the continuum of service providers.

The following are minimum standards for the provision of Case Management Services.

Agencies and individuals may exceed these minimum standards.

The level of Case Management service is determined by the Case Manager and the consumer/client beginning at assessment and should be changed as consumer/client needs change.

1.0 LEVELS OF CASE MANAGEMENT

1.1 INTENSIVE

a. Duration of relationship expected to last as long as program participation.
b. Significant involvement in coordinating services to consumer/client and/or family and household members.
c. Problem solving spans medical, mental health/substance abuse, social services, and support services. Follow-up on referrals required.
d. Consumer/client will receive a minimum of one (1) face to face contact per month from Case Manager. If the consumer/client does not follow through with scheduled appointments, the Case Manager will initiate contact.
e. Each consumer/client will have an initial plan of care written up. This care plan will be arrived at by mutual agreement during the assessment phase of service. The plan must be completed within two (2) months of the first interview. Written re-evaluation of the care plan will occur once every six (6) months. The agency shall continue with current client plan for one (1) year if the client's needs have not changed.

1.2 INTERMEDIATE OR PERIODIC

a. Duration of relationship expected to last as long as program participation.
b. Level of Case Manager's involvement in coordinating services to the consumer/client and/or family and household members will be determined by the consumer/client's needs for intervention.
c. Problem solving spans medical, mental health/ substance abuse, social services and support services and referrals. Follow-up by Case Manager on referrals will be determined by consumer/client's needs for such interventions.
d. Contact will be initiated by Case Manager or consumer/client at least every three (3) months and at least one (1) face to face contact a year.
e. Each consumer/client will have a written initial plan of care which will be re-evaluated at least annually.

1.3 LIMITED OR ONE TIME INTERVENTION

a. Clients receive a mini assessment specific to client identified problem, other issues and problems may be identified at this point. Intervention is documented.
b. Duration of relationship may be limited to specific issues.

c. Problem solving limited to resource identification.
d. Case Manager is expected to have no more than two (2) contacts. If more follow-up is necessary within a 90 day period from the initial contact, the Case Manager will re-assess the level of Case Management for appropriateness.
e. No plan of care is necessary.

2.0 PRACTICE GUIDELINES

2.1 CONSUMER/CLIENT IDENTIFICATION

To determine if an individual is eligible for services by virtue of pre-established criteria developed by the service provider.

a. The agency shall screen all individuals who call, walk-in, or schedule an appointment for Case Management services to determine the appropriateness for agency services, including verification of HIV status.
b. The agency shall make suitable referrals for those individuals who are not appropriate for agency Case Management services, but who are in need of services.
c. The agency shall assess individuals in crisis to determine what agency interventions are appropriate.
d. The agency may assign a Case Manager to eligible consumer/clients at the time of their initial contact.

2.2 INTAKE

To formally enter an eligible consumer/client into the system for further assessment and the development of the client's plan of care, it is necessary to collect all information about the consumer/client for subsequent planning, intervention and/or intake.

a. The agency shall complete an initial assessment on eligible consumer/clients at the time of intake, collecting all information as outlined on the service provider's intake forms.

Completion of these forms is required for Intensive and Intermediate Case Management.

b. Eligible consumer/clients presenting with emergency needs will have those needs addressed by the conclusion of the intake appointment. Emergency needs are defined as needs that will have serious immediate consequences for the consumer/client unless these needs are met.
c. Consumer/clients will be seen for the first Case Management appointment within five (5) working days after assignment to a Case Manager. Individuals requiring an off-site visit must be seen within ten (10) working days after assignment to a Case Manager. Exceptions are made if consumer/clients initiate cancellations.
d. The agency shall assist the consumer/client in identifying and making an appointment with a medical provider as early as possible during the time of the initial intake or the Case Management intake appointment for those consumer/clients not already connected to a primary medical care provider.

Consumer/clients are to schedule their own appointments if they are able.

2.3 PSYCHOSOCIAL NEEDS ASSESSMENT/REOURCE IDENTIFICATION

a. The Case Manager shall complete a comprehensive written psychosocial needs assessment for each consumer/client within thirty (30) days or by the conclusion of the third Case Management appointment, which ever comes first. This needs assessment shall include a medical/psychosocial history and shall be included in the consumer/client record. This is required for Intensive and Intermediate Case Management.

Areas to be covered in the psychosocial assessment:

- Presenting Problem(s)
- Living Situation
- Nutritional Status History
- Spirituality Issues
- Social/Community Supports
- Emotional/Behavioral Status
- Financial Status/Entitlement(s)/Health Insurance/Prescriptions Plan(s)
- Sexuality Issues
- Awareness of Safer Sex Practices
- Current Health Status
- Health Symptoms
- Medical History
- Family Composition*
- Psychiatric/mental health
- Legal History
- Recreational/Social Activities
- Physical/Sexual Abuse History
- Employment History
- Substance Abuse History
- Current Medications

*It is recommended that children, thirteen (13) and under, be HIV tested if either parent is HIV+.

a. The Case Manager shall ensure that each consumer/client chart contains written indications that the current needs have been discussed and/or identified at the time of the psychosocial needs assessment. Case Managers should review the listed areas of consumer/client needs when performing the psychosocial needs assessment.
b. The agency should ensure that a mini assessment specific to the consumer/client identified problems is completed for any individuals requesting Limited or One Time Interventions.

2.4 DEVELOPMENT OF THE CONSUMER/CLIENT PLAN OF CARE

With the active participation of the consumer/client and possibly others, e.g. partners, parents, guardians, medical care givers, the Case Manager shall develop an appropriate course of action to access the identified resources required to meet the needs and resolve the problems.

a. The Case Manager shall, with the active participation of the consumer/client, identify which needs are to be addressed through the development of goals and objectives. Time frames for meeting the goals and resolving the problems should also be established. These written objectives and goals are to be incorporated into the plan of care which is a permanent part of the consumer/client chart. Development of the plan of care shall be started by the third Case Management appointment or within thirty (30) working days from the date of the assignment to a Case Manager. No plan of care is necessary for limited or one time intervention. All plans of care should be signed and dated by both the consumer/client and the Case Manager.
b. The agency shall, together with the consumer/client, identify the appropriate resources needed to attain the stated goals and objectives. This resource identification shall be written in the plan of care.
c. The agency shall provide written verification that the consumer/client is either in agreement or disagreement with the goals and objectives contained in the plan of care.

2.5 IMPLEMENTATION AND COORDINATION OF CONSUMER/CLIENT PLAN

The case manager provides support, advocacy, consultation, and crisis intervention to the client and others involved in the implementation of the plan.

a. The Case Manager shall proactively attempt to contact the consumer/client after the development of the plan to implement those parts that were not executed at the time of the plan development. The plan will establish priorities among the identified needs.

b. The Case Manager shall advise the client on making arrangements with service

providers selected and on ways of gaining access to those services.

c. The Case Manager shall document in writing all referrals and outcomes initiated and/or completed as they relate to the plan of care. Any corresponding actions initiated by the client and other identified people and the outcomes resulting from these actions shall also be incorporated in the consumer/client record.

d. The Case Manager shall be in communication with the consumer/client during the Intensive level of Case Management, a minimum of one (1) contact per month to provide support, advocacy, consultation, and crisis intervention throughout implementation of the client plan. For Intermediate Case Management, the Case Manager shall be in communication with the consumer/client a minimum of once every three (3) months. There shall be at least one (1) face to face contact a year for the Intermediate Case Management level and one (1) face to face contact every six (6) months at the Intensive level.

2.6 MONITORING THE CONSUMER/CLIENT PLAN

Monitoring is performed to routinely review the success in accessing services as outlined in the consumer/client care plan, to measure progress in meeting goals and objectives, to intervene as appropriate and to revise the plan as necessary.

a. The Case Manager shall monitor the goals and objectives contained in the consumer/client plan (as the needs of the consumer/client require) to decide what steps need to take, if any. Documentation of the monitoring process shall be recorded in the consumer/client record. This monitoring shall occur a minimum of the following:

Intensive	Each client receives a minimum of one (1) contact per month from the case manager (two (2) face to face contacts a year - one (1) face to face every six (6) months)
Intermediate or Periodic	Contact can be initiated by Case Manager or consumer/client at least every three (3) months (one (1) face to face contact a year)
Limited or One Time	Case Manager is involved in no more than two (2) Intervention contacts limited to particular issues.

If a client cannot be located, after several attempts to reach by telephone and/or letter, for two (2) months, a referral is made to case finding (if available) to assist in locating the client. If the client cannot be located by the case finder within ninety (90) days, the case management record is moved to inactive status. At the end of a year, if there is no contact, the case management record is closed (for comprehensive and intermediate.)

b. The Case Manager shall monitor the services provided and the services delivery to verify that the services are being received and are sufficient in quality and quantity.

c. The Case Manager shall provide written documentation (in the progress notes) of any difficulties encountered in achieving the goals and objectives, and provide strategies in writing for resolving these difficulties.

d. The Case Manager shall make available professional supervision or consultation to all Case Managers while the plan of care is being monitored. A minimum of one hour of formal supervision once a month is required per Case Manager, with

additional case consultations on an as-needed mutually determined basis.

2.7 RE-EVALUATION OF THE PLAN OF CARE

To review the success of the implementation of the care plan and to determine if the consumer/client's needs have significantly changed since the previous needs assessment. If the needs have changed, then a new consumer/client plan should be developed. If the needs are the same, then the current plan is continued for one (1) year.

a. Each agency shall assess the consumer/client records a minimum of every six (6) months to determine the consumer/client's status and progress and whether any revision is needed in the care plan or in the provision of services. This review shall be recorded in the progress notes. The record review may be done by the Case Manager supervisor, peer review, formal audit,

b. The Case Manager shall develop, with the active participation of the consumer/client, new goals and objectives if the needs have changed since the previous needs assessment.

2.8 CLOSURE

Closure of the case at the request of the client, at the request of the agency (provided that pre-established procedures are followed), or due to death.

a. Prior to closure (with the exception of death), the agency shall attempt to inform the consumer/client of the re-entry requirements into the system, and make explicit what case closing means to the consumer/client.
b. The agency shall close a consumer/client's file according to the procedures established by the agency.
c. In Maryland, adult (over 18) records will be kept for a minimum of ten (10) years after last entry. For children (under 19) the record must be archived until the child reaches the age of 24 or six (6) years after death, if sooner.

3.0 LICENSING

a. The agency/organization will show evidence of being licensed by an appropriate body.
b. Licenses must be current and available.
c. Where applicable, staff will have licenses that are current and appropriate for providing Case Management services.

4.0 TRAINING AND SUPERVISION

The agency will provide adequate training and supervision for all Case Managers.

The agency will:
a. Maintain documentation that demonstrates that Case Management services are provided directly by, or under the supervision of, or in consultation with a licensed social worker and/or registered nurse case manager.
b. Maintain documentation for each staff person of all in-service and/or specialized training, given or taken, on pertinent topics related to HIV/AIDS.
c. Have policies that encourage and allow continuing education and professional development opportunities to be pursued on a regular basis.
d. Create a system that regularly updates the staff resource information network of available services for people living with HIV/AIDS.

5.0 CONSUMER/CLIENT RIGHTS AND RESPONSIBILITIES

The agency shall have policies and procedures that protect the rights and outline the responsibilities of the consumer/clients and the agency.

These policies and procedures include:

a. A written agency policy on consumer/client confidentiality.
b. A statement signed by the consumer/client that states that existing policies and procedures regarding confidentiality, grievance, eligibility and services have been explained to the consumer/client. Copies of eligibility criteria and services available should be given to each consumer/client requesting services.
c. System for ensuring that case records are protected and secured.
c. A written, signed consent for the release of consumer/client information that pertains to establishing eligibility for agency services.
e. A written grievance procedure
f. A statement of consumer/client rights as well as responsibilities or agency expectations of each consumer/client.
g. A statement that outlines process for both Voluntary and Involuntary Disengagement from Services.

6.0 QUALITY ASSURANCE

The agency must have a quality assurance plan to monitor both appropriateness and effectiveness of Case Management Services.

This quality assurance plan, contained in the consumer/client case file, should include:

a. The mutually established plan of care.
b. A full needs assessment with psychosocial and medical needs described.
c. Documentation of the services delivered, referrals made, advocacy efforts initiated to address the needs as presented in the care plan
d. Evidence that the plan of care was reviewed at least each six (6) months and when appropriate was modified according to the medical status of the consumer/client.
e. Evidence of linking of consumer/clients with the full range of benefits and/or entitlements.
f. Evidence of linking the consumer/client with needed services such as:
    1. Medical services
    2. Substance Abuse services
    3. Mental Health services
    4. Social Services
    5. Financial services
    6. Counseling services
    7. Educational services
    8. Housing services
    9. Other support services.
g. A process for consumer/clients to evaluate the agency, staff, and services.